FINAL REPORT
Chesterman Report Recommendation 2
Review Panel
This Report of the review panel in relation to Recommendation 2 of the Chesterman Report has been prepared for the Honourable Lawrence Springborg, MP, Minister for Health. A copy of the Terms of Reference for the review panel is provided in Attachment A.

The information contained in this report is based on a review of the files of medical practitioners who have had a complaint/notification raised against them and have been dealt with by the Medical Board of Queensland/Queensland Board of the Medical Board of Australia and AHPRA.

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EXECUTIVE SUMMARY AND CONCLUSIONS

In April 2012 the Parliamentary Crime and Misconduct Committee (the Committee) received a public interest disclosure alleging issues in relation to the conduct, regulation, registration and discipline of medical practitioners in Queensland. The Committee referred the content of the disclosure to the Crime and Misconduct Commission (CMC) which appointed retired Supreme Court Judge, Mr Richard Chesterman AO RFD QC to undertake an independent assessment of the allegation. Recommendation 2 of Mr Chesterman’s report states:

“that there be a review of all the cases of misconduct or alleged misconduct by medical practitioners, dealt with by the QBMB or in which AHPRA has recommended disciplinary action against a medical practitioner, including cases in which the Notification Advisory Committee and/or QBMB rejected a recommendation by AHPRA to take disciplinary action.”

This Final Report responds to the detailed Terms of Reference from the Honourable Lawrence Springborg, MP, Minister for Health (refer Attachment A).

1 PURPOSE OF THE REVIEW

The primary purpose of the review is to determine whether the MBQ/QBMB is achieving their primary objective of protecting the public through a process which ensures that medical practitioners are competent to practise. The objectives include protecting the public, upholding standards of medical practice and maintaining public confidence.

Specifically the review panel (“panel”) was directed to form a view as to whether the QBMB has:

- made timely responses to complaints/notifications and recommendations made to it;
- made appropriate responses to complaints/notifications and recommendations made to it; and
- for those complaints initially dealt with prior to July 2010 and transferred to the QBMB, achieved the objectives of the Health Practitioners (Professional Standards) Act 1999 as set out in s 6.

The panel was requested to have particular regard to matters in which action is recommended by the Australian Health Practitioner Regulation Agency (AHPRA), the Complaints Assessment Committee (CAC), the Notification Assessment Committee or the Performance and Professional Standards Committee (PPSC) and no action has been taken by the QBMB.

2 METHODOLOGY

The identification of files which were within the scope of the review was a complicated and difficult exercise. The panel is grateful to Ms Anne Morrison, AHPRA (State Manager Qld), Dr
Sue Sherrell Ph.D. (Project Manager), Marc Corbet, Helen Davey and the other staff at AHPRA for their efforts in creating the database that enabled us to select the files for review.

The files determined as within the scope of the review were selected according to the following inclusion criteria:

- the complaint about a medical practitioner had been received prior to the transition (1 July 2010) and remained open as of 1 July 2010. These were referred to as ‘legacy’ files;
- complaints/notifications dealt with under the *Health Practitioners (Professional Standards) Act* 1999 opened after 1 July 2010. These are also referred to as ‘legacy files’;
- notifications to AHPRA, under the *Health Practitioner Regulation National Law Act* 2009, alleging misconduct by a medical practitioner, received between 1 July 2010 and 30 June 2012, and the decision process included recommendations other than No Further Action (NFA). These were referred to as ‘non legacy’ files.

There was a total of 2,451 files (those opened after 1 July 2010 in addition to the legacy files which transitioned across from the Medical Board on 1 July 2010) of which 596 were identified by the panel as being within the scope of the review. Of the 596 files, 308 were legacy and 288 non-legacy files. Each file was examined and reviewed by the panel with respect to timeliness and appropriateness (which included compliance with legislative objectives).

The panel considered that 84 of the legacy files and 149 of the non-legacy files had been dealt with by the MBQ/QBMBBA in a timely and appropriate manner. These files, having been dealt with in an appropriate and timely manner, were therefore not examined any further by the panel. This left 224 legacy files and 139 non-legacy files remaining for review by the panel.

The panel reviewed each file with respect to the timeliness of the process in dealing with the complaint/notification and documented the time taken to progress the files from receipt of complaint/notification to the final decision of the Board. The key referral timelines considered were:

- time from receiving notification to OMBQ/AHPRA/CAC/NAC assessment;
- time to appoint investigators and conduct investigations;
- overall time from notification to final decision.

Other important factors that contributed to the timeliness of the process were considered separately:

- “immediate action” - this was legislatively required for urgent action to protect the public;
source of referral - this factor appeared to result in a duplication of effort and lack of coordination of advice that markedly extended the decision process. Referrals were made from the Office of the State Coroner, Health Quality and Complaints Commission (HQCC), private institutions and public hospitals.

The panel examined legacy and non-legacy files to consider whether decisions of the QBMBA were appropriate considering the nature or gravity of the notification. The panel also considered whether the action taken by the Board was consistent with the aims of protecting the public and maintaining competency standards within the medical profession. The report documents examples of files with respect to:

- misdiagnosis and/or failure to diagnose;
- poor medical practices and surgical outcomes;
- prescribing irregularities;
- boundary violations;
- official misconduct.

The panel examined and reviewed the statistics for the acceptance or rejection of AHPRA recommendations by CAC/NAC/PPSC/QBMBA. The results are discussed within the body of the report.

3 TIMELINESS IN RESPONSE TO COMPLAINTS/NOTIFICATIONS

The panel examined and reviewed the in-scope files with respect to timeliness of the process in dealing with complaints and notifications. The legacy and non-legacy files were considered separately with respect to the key referral timelines which were as follows:

- length of time between the receipt of a complaint/notification and an OMBQ/AHPRA/CAC/NAC assessment meeting;
- length of time between the decision to appoint an investigator and the actual appointment;
- length of time taken to undertake and complete an investigation; and
- total length of time taken from receipt of complaint/notification to a final decision by the Board.
3.1 Legacy files (for more detailed information refer 5.1)

3.1.1 Length of time from receipt of notification to OMBQ/AHPRA/CAC/NAC assessment

There were unacceptably long delays in this part of the process evident in numerous files. Of the 308 in-scope legacy files, only 75 were assessed within 60 days, with 94 not being assessed within one year and 7 not assessed within 2 years. A number of serious matters were not progressed in a timely manner and there was an obvious lack of consistency and predictability in relation to the time which complaints of a similar nature took to be progressed to the OMBQ/AHPRA/CAC/NAC assessment meetings.

Examples of clinically significant complaints that were not progressed to an assessment meeting in a timely manner included (further examples are provided at 5.1.1):

- three complaints against one practitioner alleging performance of breast augmentation that resulted in post-operative infection and displacement (17 months), re-constructive surgery resulting in facial disfigurement (16 months), and excision of the wrong lesion requiring additional surgery (20 months);

- complaints regarding boundary violations of a sexual nature took various lengths of time to reach an assessment meeting. Three cases were assessed almost immediately. Each resulted in disciplinary action. A further six (6) cases were assessed between one (1) and three (3) months, resulting in four (4) disciplinary actions. All of the three (3) cases assessed between four (4) and eight (8) months resulted in disciplinary action. Three (3) cases were assessed between 12 and 14 months with one (1) resulting in disciplinary action.

3.1.2 Length of time to appoint an investigator

Section 65 Health Practitioners (Professional Standards) Act 1999 imposes an obligation on the Board to “...ensure an investigation committee it establishes, or an investigator it directs to conduct an investigation, conducts the investigation as quickly as possible having regard to the nature of the matter to be investigated.” (emphasis added)

The length of time taken to appoint an investigator for legacy complaints ranged from 2 days to an unacceptable 39 months (appointment of second investigator), with the average time being an overly long 86 days. There is clear evidence of significant delays in appointing investigators even in the cases involving allegations of serious misconduct. Some examples are as follows (further examples are provided at 5.1.2.1):

- concerns regarding health, safety and infection control practices and allowing a non-practitioner to perform minor surgical procedures – eight (8) months;

- alleged failure to diagnose an aggressive cancer – 11 months;
• alleged inappropriate prescribing of opiates and benzodiazepams – 13 months.

3.1.3 Length of time taken to conduct an investigation

This ranged from eight (8) days to 64 months. Within this range there was considerable variability. The average time taken to complete an investigation was an unacceptably long 452 days. The length of time taken fails to reflect the seriousness of the allegations or the complexity of the investigation. Some examples of unacceptable delays include (further examples are provided at 5.1.2.2):

• 25 months – Allegation the practitioner prescribed S4 medications for patients whom the practitioner had not actually consulted with;

• 29 months – Allegations by medical colleagues regarding concerns about the practitioner’s clinical and surgical competence, medical knowledge base, communication skills and general integrity; concern as to whether the practitioner exhibited the appropriate skill, knowledge, judgement and care expected of a competent practitioner in surgery and whether the practitioner’s conduct was of a lesser standard than expected;

• 40 months – Allegation regarding the practitioner’s unnecessary administration of iron infusions to patients who did not appear to have signs of iron deficiency. Administration of these infusions in a general practice rather than a hospital setting, and whether the patients were providing a legally valid informed consent before receiving treatment.

3.2 Non-legacy files (for more detailed information refer 5.2)

3.2.1 Length of time from receipt of notification to AHPRA/NAC assessment

Section 149 Health Practitioner Regulation National Law Act 2009 states that “[A] National Board must, within 60 days after receipt of a notification, conduct a preliminary assessment of the notification…” (emphasis added)

However, in the non-legacy files only 40% of the 190 notifications opened in the year ending 30 June 2011 met this 60 day limit and only 52% of the 90 notifications opened in the year ending 30 June 2012 met this standard (refer Table 5-4). The significant variation in the lengths of time that notifications remained in this preliminary stage of the process (between notification and assessment meeting) did not appear to be correlated with the nature or seriousness of the notification, a history of prior or similar complaints/notifications about the practitioner, and/or the source of the notification.

The delay at this stage of the process results in practitioners, who potentially pose a risk of harm to the public, continuing to practise without any conditions, undertakings, supervision or mentoring to confirm their competency. Examples of notifications based on clinically significant
allegations which failed to progress to a preliminary assessment within the 60 day timeframe include (further examples are provided at 5.2.1):

- notification alleging inappropriate touching of a patient by the medical practitioner – 15 months;
- notification alleging the practitioner injected as a single dose a desensitising vaccine, at eight (8) times the recommended dose which resulted in ongoing side effects – eight (8) months;
- notification alleging that the supervising surgeon was not present in the operating theatre when a “trainee surgeon” performed an orchidectomy. The patient allegedly sustained significant and ongoing complications resulting from the surgery – seven (7) months;
- notifications alleging various degrees and forms of boundary violations which took between three (3) months (the practitioner was exhibiting excessive affectionate behaviour to female patients) and 15 months (inappropriate touching of a female patient by a practitioner). A notification alleging the practitioner inappropriately touched, and attempted to develop an inappropriate relationship with, a patient came before the assessment meeting after 10 months and a notification alleging the practitioner attempted to manipulate an 82 year old patient to obtain the patient’s home took four (4) months.

In addition, notifications based on allegations of a similar nature were not progressed to the assessment meetings at a similar rate, with many outside the 60 day timeframe. For example notifications involving allegations of a failure to adequately assess and diagnose variously took:

- one (1) month where it was alleged the practitioner failed to diagnose a pregnancy before administering an injection of Depo Provera;
- four (4) months where it was alleged the practitioner ignored the patient’s symptoms, failed to conduct an appropriate examination and incorrectly diagnosed chronic prostatitis when the patient had prostate cancer;
- six (6) months where it was alleged the practitioner did not correctly interpret the blood results of a patient who was later diagnosed with, and died from, advanced pancreatic cancer.

3.2.2 Length of time to appoint an investigator and conduct investigations (subsequent to AHPRA/NAC assessment)

The AHPRA/NAC assessment recommended which of the notifications would be progressed to investigation. While the Health Practitioner Regulation National Law Act 2009 is silent as to the precise time for the appointment of an investigator, section 162 prescribes that the National Board “…ensures an investigator it directs to conduct an investigation conducts the investigation as quickly as practicable, having regard to the nature of the matter to be investigated.”
The length of time taken to appoint an investigator varied. For notifications received in 2010, 2011 and 2012 the lengths of time ranged from a same day appointment to 14 months for an appointment to be made. The average time to appoint an investigator for notifications raised in Financial Year 2011 was 72 days, although the data provided by AHPRA explicitly excludes the 14 days taken to confirm the Record of Decisions which is entirely an internal processing matter. There was an evident improvement in timeliness for notifications opened in Financial Year 2012 with almost all investigators appointed within 46 days (though this does not include the 14 day delay to confirm the decision). Refer Table 5-5.

Examples of significant and inexplicable variations and delays in appointing investigators include (further examples at 5.2.2.1):

- in notifications involving inappropriate prescribing of Schedule 8 drugs, the time taken to appoint an investigator varied significantly with an investigator being appointed in one (1) month for one notification and not for eight (8) months in relation to another notification;

- in notifications based on unsafe prescribing practices, the time taken to appoint an investigator was inappropriately lengthy given the clinical nature and significance of the allegations. As an example, an investigator was not appointed for three (3) months after the AHPRA/NAC decision to investigate in relation to a notification that a practitioner was administering ozone injections to a patient who suffered a reaction to a salve prescribed for cancer;

- in notifications based on allegations of poor standards of medical practice, poor surgical outcomes and failure of a practitioner to diagnose were held in abeyance for seven (7), five (5), four (4) and three (3) months awaiting the appointment of an investigator.

3.2.3 Length of time taken to conduct an investigation (for more detailed information refer 5.3)

The length of time from appointment of investigator to completion of the investigation was, in many of the files, determined by the clinical complexity of the allegations as contained in the notifications. The average time taken to complete an investigation in Financial Year 2011 was 240 days (refer Table 5-6). However, it was evident from the files that a number of the notifications which went to investigation, and remained under investigation for significantly prolonged periods of time, involved single incidents and were not clinically complicated in respect of the nature of the allegations to be investigated. Examples of such excessive delays include (further examples at 5.2.2.2):

- 10 months: The notification alleged the surgeon, in relation to one (1) patient at one (1) facility, performed surgery at a standard below that reasonably expected, that the practitioner was not available by phone when post-operative bleeding commenced,
failed to obtain appropriate consent, failed to provide adequate postoperative advice, failed to keep adequately detailed medical records, practised solo in breach of his registration conditions and billed Medicare twice for the one (1) service. It is of particular note that the investigator was aware of admissions by the practitioner as to the allegations two months after the investigation commenced being eight (8) months before completion;

- 10 months: The notification alleged severe post-surgical complications. It is noted that the investigator did not seek an expert opinion report until five (5) months after the investigation was commenced and the report took two (2) months to be completed and returned (7 months after the investigator was appointed). This matter took 15 months from the time the decision was made to investigate to the completion of the investigation;

- 13 months: The notification alleged a teenage patient (diagnosed with an eating disorder and suicidal ideation) had been prescribed Dexamphetamine despite her continued weight loss. This matter took 15 months from the date the decision was made to investigate to the completion of the investigation.

3.3 Total time taken from receipt of complaint/notification to final decision by the Board

Given the delays between the receipt of a complaint/notification and the assessment meeting, a recommendation to appoint an investigator and the actual appointment, and the time taken to undertake and complete the investigation it was inevitable that the files would evidence lengthy delays between receipt of complaints/notifications and final decisions.

The average time taken to reach a final decision for legacy complaints was 585 days and the time taken to reach a final decision for notifications raised in Financial Year 2011 was 288 days.

The panel acknowledges the improvement in relation to timeliness between the legacy and non-legacy files managed by AHPRA. Nonetheless, of the notifications received in 2011, 68 had not been subject to a decision within 365 days. There has been a further improvement in timeliness for notifications received in 2012. Of the 90 notifications received in 2012, all but 5 of the files within scope had been decided upon within 12 months (refer Table 5-7), with 45 decided within 180 days and 40 between 180 and 365 days (this data excludes files that remained open as at 30 June 2012).

3.4 Specific issues in relation to timeliness (for more detailed information refer 5.4)

The panel noted a number of specific issues which emerged in relation to the timeliness of the Board to respond to the conduct of practitioners and, the time taken to progress a matter from
receipt of a complaint/notification to a final decision by the Board. These issues were considered separately and included:

- the ability of the Board to take “immediate action” to protect the public;
- the source of a complaint/notification which may be from Queensland Health, a private sector health facility or the Office of the Coroner where investigations and high levels of scrutiny may have already been undertaken;
- the legislatively prescribed cross-jurisdictional obligations imposed on the HQCC and the Board in relation to receipt of notifications, consultation and information sharing; and
- the involvement of other entities such as the Drugs of Dependence Unit (DDU), Medicare, the Federal and Queensland Police Services.

3.4.1 Immediate action

Section 156 (1)(a) Health Practitioner Regulation National Law Act 2009 empowers the Board to take ‘immediate action’ in relation to a practitioner if “[A] National Board reasonably believes that- (i) because of the registered health practitioner’s conduct, performance or health, the practitioner poses a serious risk to persons; and (ii) it is necessary to take immediate action to protect public health or safety…” Immediate action is defined under section 155 Health Practitioner Regulation National Law Act 2009 to mean suspension, the imposition of a condition, accepting an undertaking or accepting the surrender of the health practitioner’s registration.

Of concern to the panel was the actual process, as prescribed by the legislation, which hampers rather than facilitates the taking of ‘immediate action’ on receipt of a notification about a practitioner who is potentially an immediate and significant risk to the public. The provision, which requires the Board to give notice of the ‘immediate action’ and then invite a submission from the practitioner before action can be taken, results in the practitioner continuing to practise while this protracted process is undertaken.

Under the Health Practitioners (Professional Standards) Act 1999 the MBQ, on forming a reasonable belief that a practitioner posed a serious potential risk to the wellbeing of vulnerable persons was able to take actual “immediate action” to suspend, or impose conditions on the practitioner’s registration if it was “necessary to protect the vulnerable persons.” The written notice of the decision of the Board was given to the practitioner immediately after the decision to suspend or impose conditions was made and not before. The Board was therefore capable of actually taking immediate action to protect the public. Based on the following examples the panel was of the view that the provisions of the Health Practitioners (Professional Standards) Act 1999 were more effective in fulfilling the obligations of the Board to protect the public. The legislative provisions under which the QBMBA are now constrained results in a delayed process in which the risk to the public continues to exist until a sequence of correspondence is exchanged.
and a submission lodged and considered by the Board. It is of significance that the existing legislation does not prescribe a timeframe for this process.

**Immediate action taken under the Health Practitioner Regulation National Law Act -2010**

‘Immediate action’ was taken in response to six (6) notifications received in 2010. Examples of the notifications resulting in an ‘immediate action’ included allegations of the practitioner exchanging prescriptions for sex, prescribing Schedule 8 drugs without the requisite authority or beyond the terms of the practitioner’s endorsement and perforating the patient’s uterus during a hysterectomy. It was noted, in relation to the latter file, the practitioner had an additional outstanding matter before the Board.

**Immediate action taken under the Health Practitioner Regulation National Law Act -2011**

‘Immediate action’ was taken in relation to ten (10) notifications received in 2011. Examples of the notifications resulting in an ‘immediate action’ included allegations that the practitioner had engaged in a sexual relationship with a patient, allegations of poor surgical outcomes in relation to a number of patients and consequential changes to the practitioner’s clinical privileges, allegations of boundary violations, inappropriate prescribing, the practitioner being intoxicated while treating patients, adverse surgical outcomes, suspension of hospital accreditation and breaching existing conditions.

**Immediate action taken under the Health Practitioner Regulation National Law Act 2012**

‘Immediate action’ was taken twice in 2012 for in-scope files, once in relation to a notification alleging inappropriate prescribing practices and on a second occasion in relation to a notification alleging the practitioner struck a restrained patient with his fist.

### 3.4.2 Source of the complaint/notification

It is of concern to the panel that complaints/notifications received by AHPRA took little account, in terms of the application of the disciplinary process, of the source of the notification. The panel was concerned that notifications made by Queensland Health, private health care facilities and the Office of the State Coroner were treated in the same manner as notifications made by the public. The process did not provide the Board with the ability to expedite these notifications in a timely manner commensurate with the level of scrutiny and investigation that had been undertaken before the notification had been received by AHPRA (refer 5.4.2 for further details). Notifications from the Office of the State Coroner were dealt with over a period of time ranging from 60 to 831 days. These particular notifications were of concern to the panel due, not only to the length of time taken to process, but the decisions of the Board which seemed manifestly inadequate in a number of the files given the findings and recommendations of the Coroner. As an example (further examples are provided at 5.4.2):

- in a notification taking 60 days from receipt of notification to the final decision by the Board, the Coroner found the death of an elderly patient was caused by pulmonary thromboembolism, deep vein thrombosis, fractured neck of femur, pneumonia, chronic...
obstructive airways disease and hypertension. The Coroner found, based on evidence including the practitioner’s submission, that the practitioner “considered [the patient] had not sustained a fracture…did not order any X-ray or other review. …[ordered] pain relief … [and] It appears [the practitioner] only examined [the patient’s] knee”. The failure of the practitioner to adequately examine and diagnose was inconsistent with two (2) other practitioners who were able to offer preliminary diagnosis without further testing. The Notification Assessment Officer’s recommendations included “1. Issue a notice [to the practitioner] to show cause…as to why conditions should not be placed on his registration in relation to attending further training and/or education in geriatric medicine. OR 2. Request further information from [the practitioner] and resolve to hold the matter in abeyance pending receipt from [the practitioner] of information in relation to his CPD activities. OR 3. Place the matter into investigation…”. However, the decision of the NAC noted by the Board was NFA “because the notification was lacking in substance”.

3.4.3 Health Quality and Complaints Commission (for more detailed information refer 5.4.3)

The cross jurisdictional referral and consultation obligations imposed respectively under the Health Practitioner (Professional Standards) Act 1999, Health Quality and Complaints Commission Act 2006 and the Health Practitioner Regulation National Law Act 2009, in relation to complaints/notifications, resulted in substantial delays and inconsistencies in the processing and outcomes of a significant number of files. The disciplinary process was held in abeyance, stalled or abandoned in a number of files as the different entities attempted to comply with the reciprocal notification, consultation and information sharing dictated by legislative provisions necessary to progress a complaint/notification. The present legislation results in a blurring of the roles of the HQCC and the Board and duplication in assessment, independent clinical advice, and expert opinions. In a number of files the Board refused to accept a referral on the ground there was no substance or ground for disciplinary action when the HQCC had previously assessed the complaint/notification as suitable for the Board to deal with as a disciplinary matter. Where the Board did accept the referral the decision of the Board was to take NFA (refer 5.4.3 for examples of files reviewed by the panel).

3.4.4 Involvement of other entities (for more detailed information refer 5.4.4)

Delays in processing complaints/notifications were, in a small number of files, delayed due to the involvement of other entities such as the DDU, Medicare and the Federal and State Police who were individually conducting their own investigations simultaneously with the processes of AHPRA and the Board.

Considerable delays, particularly in relation to the time taken to investigate for both legacy and non-legacy files, were directly attributable to the slow response of medical experts in providing opinions in response to an investigator’s request or as part of the assessment process.
4 Appropriateness of QBMBBA decisions in light of the nature of the notification

The panel considered the predictability, consistency and ‘appropriateness’ of the outcomes of MBQ/QBMBBA decisions in light of the overarching obligation of the MBQ/QBMBBA to protect the public and ensure that practitioners are safe and competent to practise. In a significant number of the files reviewed (both legacy and non-legacy) the decisions of the Board were neither consistent and/or predictable across complaints/notifications of a similar nature. In addition, the panel found that decisions of the Board were, in a number of files reviewed, inappropriate and inadequate to protect the public and failed to address the assessment, confirmation or monitoring of a practitioner’s competency to practise. Examples of such decisions are provided below in this summary, and more examples with further details are provided at 6.1 to 6.5.

4.1 Misdiagnosis and/or failure to diagnose (for more detailed information refer 6.1)

It was noted by the panel that the majority of the 58 files (both legacy and non-legacy), examined on the basis of complaints/notifications that practitioners had misdiagnosed or failed to diagnose, resulted in a Board decision of NFA. This was the outcome even when complaints/notifications were based, as acknowledged by the Board in their own Reasons for Decisions, on clinically and professionally significant allegations. The following provides a few of many examples of decisions which are clearly inappropriate in protecting the public and ensuring the practitioners are safe and competent to practise:

- notification that the practitioner failed to review or action a patient’s abnormal histopathology result which was positive for adenocarcinoma, failed to inform the patient of the abnormal result and later attempted to conceal the histopathology result. AHPRA recommended Discipline by Panel however, the NAC sought an investigation (which took 14 months to conclude). The investigation found that there was sufficient evidence “on which the Board could form a reasonable belief that [the practitioner’s] professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or his professional peers”. The decision of the Board was to Caution the practitioner;

- notification in relation to another practitioner in the same clinical unit (as described in the example above) alleging the practitioner failed to review, or action, a patient’s abnormal histopathology results which were positive for adenocarcinoma, failed to inform the patient of the abnormal results and failed to coordinate appropriate follow up care which resulted in a three (3) month delay in the patient receiving appropriate treatment. AHPRA recommended NFA however the NAC sought an investigation which was completed after 14 months. The investigation concluded that “there is sufficient evidence on which the Board can form a reasonable belief that the practitioner’s
performance amounts to unsatisfactory professional conduct or professional misconduct” The decision of the Board was NFA;

- notification alleging that the practitioner incorrectly advised a patient in relation to the results of a breast ultrasound and mammogram which resulted in a delay in the diagnosis of breast cancer and the consequential spread of the cancer to the patient’s spine and lymph nodes. While AHPRA requested an Investigation, the NAC sought Show Cause Caution which was approved by the Board and for which the practitioner provided a submission. The Board’s decision, to Caution the practitioner, appears profoundly inadequate when considered against the Board’s own Reasons for Decision that: “[the practitioner’s] clinical notes are inadequate and fall below the standard of acceptable record keeping…[the practitioner] failed to understand the significance of the ultrasound performed … in light of the patient’s previous episode of breast disease…[the practitioner] did not take action to investigate the presence of lymph nodes on the ultrasound report and does not appear to have followed any logical clinical process in the management of the patient”;

- notification alleging the practitioner failed to diagnose two (2) cerebral aneurysms on a CT scan of a patient who presented complaining of acute headache, vomiting and being unable to sit upright. Although the radiologist reported the CT scan showed a subarachnoid haemorrhage the practitioner, after reviewing the CT scan, took no action advising the patient she had not suffered a stroke, prescribing an injection for the pain and discharging the patient home. The patient continued to suffer “cluster headaches” and, three (3) years later, sought a second opinion. The patient was then diagnosed with the cerebral aneurysms (which were visible on the previous CT scan) and underwent surgery. AHPRA and NAC recommended a Show Cause Caution which was adopted by the Board and resulted in the submission by the practitioner. The practitioner was Cautioned with “Disciplinary action not recorded on the public register”. The Reasons provided by the Board included; “There was sufficient evidence to form a reasonable belief that a disciplinary matter exists…[the practitioner’s] submission admits that an error occurred when he failed to notice either the contents or significance of the report and his failure might have had very serious consequences for the patient”;

- notification alleging the practitioner (who had been treating the patient for the previous seven (7) years) failed to adequately assess and diagnose the patient’s symptoms, failed to instruct the patient to go to hospital if the pain increased, denied knowledge of the patient when contacted by Police after the patient’s death and would not sign the patient’s death certificate because the practitioner was on holiday. AHPRA and NAC sought a Show Cause Caution, which was accepted by the Board. The practitioner responded to this decision with a submission following which the Board decided to approve the recommendation of the NAC not to Caution the practitioner but rather made a final decision of NFA.
4.2 Poor medical practices and surgical outcomes (for more detailed information refer 6.2)

There was a total of 142 complaints/notifications received in relation to poor medical practices and surgical outcomes. Outcomes were varied and included 87 NFA’s, 20 Discipline by Hearing, 14 referrals to QCAT, five (5) Undertakings and four (4) Panel referrals. There was one (1) practitioner referred for Performance Assessment.

There are numerous instances in which the notifications in relation to poor medical practices and surgical outcomes did not result in Board decisions which appropriately addressed the significance of the complaint/notification and the obligation of the Board to protect the public by assessing and ensuring the practitioner’s competency to practice. This is illustrated by reference to the following examples:

- in a notification made by an employing health care institution it was alleged the practitioner had firstly, failed to follow the institution’s head injury protocol when assessing a patient who subsequently died from an inoperable subdural and intracranial haemorrhage and secondly, supervised a junior practitioner to carry out a procedure which resulted in the patient’s condition deteriorating and requiring transfer and surgical intervention at another health care facility. The employer had, based on the practitioner’s conduct, reduced the practitioner’s scope of practice however the practitioner failed to notify the Board as required by s 130 Health Practitioner Regulation National Law Act. The NAC’s decision to take NFA, as the practitioner’s conduct was being addressed by Clinician Performance Support Services (CliPSS), was noted by the Board. While the involvement of CliPSS may have been sensible, it was not appropriate that the practitioner did not face more formal disciplinary outcome;

- in relation to a complaint alleging the practitioner “nicked the bowel”, and failed to provide adequate post-operative care resulting in the patient being transferred to another hospital with “a 2 cm hole in her stomach which had apparently become septic”, the Board, without conducting an investigation or obtaining independent expert opinion, noted the NFA decision of the NAC. The determination of the NAC was based on the finding that “this complaint does not provide a ground for disciplinary action as required by s48 of the Health Practitioners (Professional Standards) Act 1999.” It is of note that at the time this complaint about the practitioner was being dealt with by the NAC, and Board, there had been three (3) previous complaints received by the Board of which two (2) were referred to the HQCC and the third rejected.

4.3 Prescribing irregularities (for more detailed information refer 6.3)

The nature of the 47 complaints/notifications (legacy and non-legacy) examined by the panel based on allegations of poor prescribing practices by practitioners varied greatly. The outcomes of these files also ranged from NFA (18 files), to referral to QCAT (13 files).
The following are examples of complaints/notifications in which the Board determined that the decision of NFA was the appropriate outcome (further details are provided at section 6.3). The panel considers that this outcome was not adequate to protect the public and ensure that practitioners are safe and competent to practise. It is noted that the practitioners were effectively enabled, by the Board decisions, to continue their practice without any assessment of their competency, monitoring, supervision or oversight of their practice. In one of the files described below the decision was based on the practitioner’s ‘word’ as to what they had done, and would do, so as not to repeat their mistake:

- the practitioner administered, by single injection, of four (4) months supply, eight (8) doses of a medication to a patient which resulted in on-going side effects. The practitioner advised that the serum had been administered by him even though it was not clearly marked with the patient’s name or a description of the contents or any form of instructions. The practitioner “advised that he did not have any knowledge regarding this practice before he obtained patient consent and administered the serum”. AHPRA and NAC recommended a Show Cause Caution which was adopted by the Board and to which the practitioner responded with a submission. The final decision of the Board was NFA which was based on the following reasons; the practitioner had “provided a satisfactory response…taken steps to ensure that the situation does not reoccur…advised he was planning to attend relevant training about “minimising the risk of medical errors”…has attended a workshop on the topic of “Adverse Outcomes”…[and] there is little evidence that the patient suffered long term harm”;

- the notification was made by the estranged husband of the patient for whom the practitioner was prescribing dexamphetamine. The allegations included the practitioner was prescribing the drug when he “should have known” the patient had addiction problems, ignored the signs of addiction, prescribed “roughly four times the maximum recommended therapeutic dose and prescribed large amounts with repeat doses. It was alleged the practitioner commenced the patient on large doses of atomoxetine and supplied scripts for 200 tablets of clonazepam “simply to supply her with a massive quantity of benzodiazepine”. Both AHPRA and NAC recommended an Investigation which was completed in seven (7) months. The investigator found the behaviour of the practitioner constituted unprofessional conduct and recommended the practitioner undergo further education and training and a period of supervised practice. AHPRA, based on the Investigation Report and recommendations, sought the imposition of Conditions (in line with the recommendation) however the PPSC recommended NFA which was adopted by the Board on the ground that the notification “does not reach the threshold for a discipline matter”.

8 April 2013
4.4 Boundary violations (for more detailed information refer 6.4)

There were 29 boundary violations which were, in the main, of a sexual nature. Outcomes included 14 NFA’s, 8 referrals to QCAT and 5 Discipline by Hearing. In relation to boundary violations there was evidence of a high rate of disciplinary action with the decisions of the Board appropriately addressing the protection of the public. There was a pattern of recidivism identified in relation to this category of complaint/notification with two (2) complaints against two (2) practitioners, three (3) against another and four (4) against another practitioner.

The following files illustrate the imposition by the Board of more severe outcomes as the nature of the alleged offences were considered to be more grievous:

- a former patient made a complaint alleging that the practitioner had a consensual sexual relationship with her, and made uninvited sexual advances during a consultation. An investigation was conducted and it was concluded that there was insufficient evidence to form a reasonable belief that a disciplinary matter existed. It was recommended that the Board take NFA and write to the practitioner reminding him of his obligations in maintaining professional boundaries. Subsequently it was determined, following consultation with the HQCC, to rescind the previous decision and, in substitution, recommend to the QBMBA the matter be dealt with by establishing a disciplinary committee to conduct Disciplinary proceedings by way of a Hearing. It is noted that there were significant delays in the completion of this file. Eight (8) months elapsed from the date of the complaint to the first recommendation. The Investigation took 11 months to report and a further four months for the final decision of the Board to be implemented. No conditions were imposed, or undertakings made, during the 833 days of the case history;

- a complaint alleging the practitioner engaged in a sexual relationship with a patient over a period of at least seven years and that further, the practitioner had inappropriately touched two other patients and had had sexual relationships with another two patients. A period of 13 months elapsed before the first recommendation was made. An investigation was conducted and it was determined that there was sufficient evidence to form a reasonable belief that the practitioner had engaged in a sexual relationship and that a disciplinary matter existed. Furthermore it was shown that the practitioner had provided a sworn statement to the Board which was later proven to be false. The matter was referred to QCAT;

- a complaint alleging the practitioner had violated professional boundaries by inappropriately touching a patient. The patient was, because of their history of drug abuse considered a vulnerable person who was dependent on the practitioner for the prescription of benzodiazepams. The Board accepted the referral of the patient’s complaint from the HQCC as two other complaints against the practitioner of a similar nature had been investigated. While the time to first recommendation was short
days), it took five (5) months to appoint an investigator, 11 months to complete the investigation and a further four (4) months for the Board to make a final decision. It was determined that there was sufficient evidence to form a reasonable belief that a disciplinary matter existed and the matter was to be referred to QCAT and dealt with in conjunction with the other three complaints about the practitioner previously referred to QCAT.

4.5 Official misconduct (for more detailed information refer 6.5)

Official misconduct accounted for 87 complaints/notifications. Examples of allegations within this category included the fraudulent issuing of certificates, inaccurate reporting and medico-legal assessments, fraudulent entries in medical records, unauthorised access to medical records, fraudulent claims for home and practice visits, coercion of patients to make unwise financial investments, breaches of supervisory duties or regulatory conditions and unacceptable communication/behaviour such as rudeness, intoxication and lewdness. The number of decisions by the Board to take NFA (66) was high in relation to this category of complaint/notification. The following provides examples of the nature and outcomes of allegations dealt with in this category:

- a number of allegations were received claiming that the practitioner had assaulted one colleague at work and was aggressive and intimidating towards other colleagues. It was believed the practitioner had a history of Bipolar Disorder and some colleagues believed the practitioner was showing signs of a manic condition, while others did not. The practitioner had practised medicine in Queensland for several decades and had two previous unfounded complaints, one in 1998 and one in 1999. Both were assessed by the Health Rights Commission and closed with NFA being taken by the Commission or the Board. The practitioner was health assessed soon after receipt of the allegations and found not to be impaired. The Board was unable to progress investigation of the matters in relation to the assault/bullying allegations as the complainants would not assist in the investigation and there were no other avenues of enquiry available. The complainants indicated that the practitioner’s subsequent professional behaviour had been appropriate and no further action was taken;

- there was a pattern of complaints against practitioners alleging poor standards of interpersonal behaviour such as rudeness and discourtesy towards patients and staff, arrogance, denigrating behaviour, disinterest and criticism of professional colleagues. These complaints usually led to a final decision of NFA either because there were insufficient grounds to proceed or there was extreme difficulty in establishing facts relating to the matters.
5 ACCEPTANCE/REJECTION OF AHPRA RECOMMENDATIONS

The 596 in-scope files were specifically reviewed and examined from the perspectives of acceptance or rejection of OMBQ/AHPRA recommendation by CAC/NAC/PPSC/QBMBRA at first and final decision points (for more detailed information refer 7.0).

5.1 First recommendation

In relation to the first OMBQ/AHPRA recommendation 61% (364) of the recommendations were accepted with 33% (198) being rejected. A further 6% (34) of recommendations were “Own Motion” by the Board, HQCC/delegate and therefore classified as not applicable (refer to Table 7-1 and Figure 7-1). The rate of acceptance of the first recommendation differed considerably between in-scope legacy and non-legacy files. There was an acceptance rate of 70% (214) and a rejection rate of 23% (71) in the legacy files (refer to Figure 7.2). In comparison, 52% (150) of first recommendations by AHPRA were accepted and 44% (127) rejected in non-legacy files.

In the 71 (of the total 198) legacy files in which the first recommendation by OMBQ/AHPRA was rejected, 34% (24) rejected further action, 25% (18) rejected a recommendation for NFA and in 41% (29) similar action was proposed (Refer Figure 7-4). In 25% (18 files) greater action was recommended and in 32% (23 files) action of a lesser magnitude was recommended. In the 127 (of the total 198) non-legacy files in which the first recommendation by AHPRA was rejected 44% (56) rejected further action, 24% (31) rejected NFA and in 32% (40) similar action was proposed (Refer Figure 7-5). In 25% (32) greater action was recommended and in 42.5% (54) action of a lesser magnitude was recommended.

5.2 Final recommendation

The overall rate of acceptance by the Board of the final recommendation from OMBQ/AHPRA/CAC/NAC/PPSC was 89% (529) with 7% (41) rejected and 4% (26) not applicable/open (refer Table 7-3 and Figure 7-6). Both legacy and non-legacy files demonstrated very similar rates of acceptance (90% legacy and 87% non-legacy). Each had a rejection rate of 7% (legacy 21 and non-legacy 19 files). The total number of files in which the final recommendation was rejected by the Board was 41. Of these 21 were legacy files and 20 were non-legacy files.

For legacy files the Board rejected 5% (1) of the final recommendations of NFA and rejected 47% (10) proposed further actions. In the remaining 48% (10) files the Board proposed similar action (Figure 7-9). In the 21 legacy cases in which the final recommendation of OMBQ/AHPRA was rejected, 10% (2) resulted in greater action from NFA to Discipline by Correspondence and Advice, and 50% (10) resulted in action of a lesser magnitude. In each of these cases the final decision was NFA from recommendations for Discipline by Hearing (1) Undertaking (2), Discipline by Correspondence(2), Further Investigation and Other Decision (5). The remainder resulted in similar action.
For the non-legacy files the Board rejected 15% (3) of the final recommendations of NFA and rejected 65% (13) of the proposed further actions. In the remaining 20% (4) of files, the Board proposed similar action (Figure 7-10). In the 20 non-legacy files in which the final recommendation of OMBQ/AHPRA was rejected 15% (3) resulted in greater action from NFA to Caution (2) and Show Cause Caution (1). Thirteen cases (27%) were converted by the Board to NFA from final recommendations of Show Cause Caution (9), Show Cause Undertaking (1), Caution (2) and Performance Assessment (1). Five of the decisions to convert to NFA were based on submissions from practitioners while it was noted by the Board on three (3) occasions that the notification was lacking in substance.

6 CONCLUSIONS

The panel has completed the examination of the 596 files which were determined as being within the scope of the Chesterman Report Recommendation 2 Terms of Reference. Of these files, 233 were considered by the panel to have been dealt with in a timely and appropriate manner, compliant with the legislative objectives. This report therefore focuses on the 363 files (224 legacy and 139 non-legacy) which the panel considered as not having been dealt with in a manner that was timely and/or appropriate and/or in compliance with the legislative objectives.

The issues emerging from these files included:

- delays in the timeliness of complaints/notifications progressing from receipt through the various assessment and disciplinary processes to a final decision by the Board.
- a lack of consistency and predictability of outcomes in the decisions of the Board across complaints/notifications of a similar nature;
- considerable delays and inconsistencies in a significant number of files resulting from the cross-jurisdictional referral, consultation and information sharing obligations imposed under the current legislative scheme.

Legacy Files

The panel's assessment of the "legacy" files, which were subject to the Health Practitioners (Professional Standards) Act 1999 and handled by the MBQ or transitioned from the MBQ to AHPRA/QBMBBA, was that a significant proportion of the in-scope files had not been handled in a timely manner. Seven (7) were dealt with in less than 60 days while 83 took over two (2) years.

The panel considered of particular significance the extensive delays in the time taken from the receipt of a complaint to the first assessment meeting, and the time taken from a decision to investigate, to the conclusion of an investigation. Despite the legislation imposing an obligation on the Board to ensure the investigation process was conducted as “quickly as possible having regard to the nature of the matter” the delays were manifestly long, varied considerably, and indicative of a low level of compliance with the legislative prescription.
In the majority of the files examined, delays in processing a complaint during the stages of the process (assessment, appointment of an investigator, completion of an investigation) resulted in the practitioners, who potentially posed a risk of harm to the public, continuing to practice without their competency having been assessed or the safeguards of conditions, undertakings, supervision or monitoring being in place. In terms of the time taken from receipt of complaint to a final decision by the Board the time ranged from 36 to 2,368 days which, even allowing for differences in the clinical significance of complaints, is indicative of a process lacking in direction, management and rigour.

The panel considered the appropriateness of the decisions of the Board in the legacy files and formed the view that the outcomes were neither consistent nor predictable based on the nature and/or clinical significance of the complaints. In a significant number of the legacy files the decisions of the Board did not appear to be sufficiently directed to whether the practitioner was competent to practice. The panel formed the view that in a very significant number of the files the decisions of the Board were difficult to reconcile with the overriding legislative obligations. The panel thereby concluded that the processes of the Board, as evidenced by the time taken and decisions of the Board in a significant number of the files, failed to “protect the public…uphold the standards of practice…and maintain public confidence” as required under the Health Practitioners (Professional Standards) Act 1999.

Non-legacy Files

The panel considered the timeliness of the progression of non-legacy files in light of the legislative obligations imposed on the Board under the Health Practitioner Registration National Law Act 2009. The legislation provides that the Board must ensure that a preliminary assessment is conducted on a notification “within 60 days after receipt” and an investigation is conducted “as quickly as practicable”.

The non-legacy files evidenced a significant number of notifications which were not progressed to assessment within the legislatively prescribed timeframe of 60 days nor investigated “as quickly as practicable”. In addition, it was the opinion of the panel that the inordinate delays in the time taken to progress a significant number of notifications through the process after receipt, did not correlate in any predictable or consistent way with the nature or seriousness of the notification, any history of prior or similar complaints/notifications, or the source of the notification, such as the Office of the State Coroner. As with the legacy files, the delays in processing a complaint during these stages of the process resulted in the practitioners, who potentially posed a risk of harm to the public, continuing to practice without their competency having been assessed or the safeguards of conditions, undertakings, supervision or monitoring being in place.

The time taken from receipt of a notification to a final decision by the Board in the non-legacy files ranged from 110 to 635 days with the average time for notifications raised in Financial Year 2011 being 288 days. Although the length of time taken from receipt of a notification to a final
decision by the Board varied greatly in both the legacy and non-legacy files it was evident that the overall length of time is progressively decreasing since the transition on 1 July 2010.

Notwithstanding the improvements made, the panel concluded that the processes followed by AHPRA, and the QBMBA, do not meet reasonable expectations that notifications are consistently and predictably dealt with in a timely manner. Furthermore, there were a number of examples where serious notifications, indicating that the public was at risk of harm, were not handled with the urgency that was required in the particular circumstances. Accordingly, the processes followed by AHPRA and the Board demonstrated an inability to effectively prioritise and manage the progression of notifications from the time of receipt to the final decision of the Board.

A review of the files in which ‘immediate action’ was taken by the Board demonstrated that the existing provisions in the Health Practitioner Regulation National Law Act 2009 effectively hindered the Board in taking actual ‘immediate action’ when it reasonably believed a practitioner posed a serious risk to the public. The panel considered that the current provisions require amendment to empower the Board to immediately respond as opposed to engaging in an exchange or correspondence and seeking submissions from the practitioner before any action can be taken.

The panel considered the appropriateness of the decisions of the Board in the non-legacy files and formed the view that there was no pattern of consistency or predictability of outcomes across complaints/notifications of a similar nature. In addition it was found that the decisions lacked congruence with the nature and clinical significance of the complaints/notifications. For example, there were a considerable number of files where it was indicated that assessment, confirmation or monitoring of a practitioner’s competence to practice was required, however there was a failure to take such action. This was evident in files in which the Board made a decision to Caution a practitioner, a step which did not address the issue of the practitioner’s competence, nor provide any oversight or supervision of ongoing practice.

There was a considerable degree of variability in relation to the outcomes of the various categories of complaints/notifications. Prescribing irregularities demonstrated the highest proportion of disciplinary action (62%) with 27.5% being referred to the QCAT and the Board deciding to take NFA with respect to 38%. Boundary violations resulted in the next highest rate of disciplinary actions at 51% of the files. The clear legislative framework applicable to drugs and poisons in Queensland and the explicit societal expectations in relation to appropriate behaviour, especially behaviour of a sexual nature, may have facilitated assessments and decisions in these categories of complaints/notifications. Conversely, the rate of disciplinary action in response to official misconduct allegations was only 14%. This may be indicative of the Board’s difficulty in assessing the precise parameters for disciplinary measures in response to this category of conduct, or a perception by the Board, that this type of conduct does not warrant a disciplinary outcome.
Complaints/notifications that were of a specific clinical nature had lower rates of disciplinary action. Of the complaints/notifications relating to misdiagnosis/failure to diagnose, 34% resulted in disciplinary action. Complaints/notifications of poor medical practices and surgical outcomes resulted in a disciplinary action rate of 38%. As noted in relation to the legacy files the panel was of the view, based on the in-scope files for review that the rate of disciplinary action was low if the objective of the disciplinary process is protection of the public from risk of harm.

Given that the practitioners whose in-scope files were examined have been fully dealt with by the Board, there are no reasonable grounds for the matters determined by the Board to be reconsidered. However, should there be evidence of criminal acts then it is open for the Queensland Police Service to bring charges. These aspects are matters which have been considered in the report prepared by Mr J. Hunter SC and are outside the terms of this panel.

The cross jurisdictional referral and consultation obligations imposed respectively under the Health Practitioners (Professional Standards) Act 1999, Health Quality and Complaints Commission Act 2006 and the provisions of the Health Practitioner Regulation National Law Act 2009 were considered, by the panel, to result in considerable delays and inconsistencies in both the progression and outcomes of complaints/notifications in a significant number of the files. The panel was of the opinion that the current legislative requirement for two (2) separate and distinct entities to co-manage notifications through reciprocal referral and consultation processes is an unnecessary duplication of activities and resources and requires immediate consideration either to change the provisions of the legislation or consolidate the roles of the entities.

The panel considered that changes to the processes by AHPRA and the Board which would improve timeliness and suitable prioritisation include:

- appointing one or more experienced and senior investigators to conduct “triage” on notifications, fast tracking investigations and Board decisions in matters which raise immediate concern about the safety of the public based on the nature of the notification, the source and detail of the notification and the nature of prior notifications (if any) concerning the practitioner;

- introduction of a defined “triage” process so as to ensure that appropriate priority is given to notifications from entities which have undertaken some initial form of investigation and have experience in assessing the conduct and behaviour of practitioners. Examples of such entities to include the Office of the State Coroner, Queensland Health and private health care institutions;

- establishing a more effective case management system whereby:
  - timelines for assessment, investigations and decisions are established;
  - overview systems are put in place so deviations from timelines are identified and managed to ensure that the timeline is met or, when necessary modified to take into account unpredicted developments;
any such modifications to the established timeline should be subject to being overruled by the Board;

- simplifying the process whereby the multiple internal referrals of decisions between committees and the Board are streamlined and endorsed by the Board rather than the existing process whereby the Board is required to endorse each individual decision.

In relation to the appropriateness of decisions, the panel concluded that there was clear evidence that the processes followed by AHPRA and the QB MBA to reach decisions based on notifications, were not adequately protecting the public. In particular:

- the decision making processes for the progression of a notification from receipt to final decision did not appear to be consistent in application across notifications of a similar nature;
- practitioners who were identified by expert opinions, Investigation Report findings (and recommendations) and the Boards own Reasons for Decision as having demonstrated a lower standard of professional behaviour, skill and competence often faced little or no sanctions. This was the outcome for a significant number of complaints/notifications based on clinically significant allegations. A matter of great concern to the panel was the disproportionately high level of Board decisions to take NFA in response to complaints/notifications, which on their face, evidence the basis for significant concern, have been referred by the State Coroner after an Inquest or by Queensland Health or private sector health facilities after internal investigations.

The members of the panel had sufficient experience to be able to come to a view that the decision making processes taken by AHPRA and the Board are much more lenient in relation to medical practitioners than other regulated practitioners.

Having reviewed the decisions made by the QB MBA in relation to the “non-legacy” files, the panel came to the view that consideration should be given to the following changes:

- to ensure and improve consistency of decisions, a formal process should be put in place whereby prior decisions of the Board and/or of QCAT, in relation to similar matters, are formally reviewed by the Board prior to a new decision being taken to ensure that subsequent matters are in range and consistent over time;
- this review of decisions should include decisions taken for similar notifications and findings in relation to other regulated health professionals such as nurses, pharmacists and dentists;
- to ensure that the process is transparent and that the decisions of the Board are subject to public scrutiny, summaries of the decisions of the board, suitably de-identified, should be released on a regular basis;
• to ensure consistency across the various regulated professions, the membership of the Board should be changed promptly so that a majority of its members are not medical practitioners. It is suggested that:
  
  o the chair of the Board is not a medical practitioner;
  
  o a proportion of the new members includes practitioners other than medical practitioners who have served on boards which regulate other practitioners (such as nurses, dentists and pharmacists); and
  
  o a higher percentage of community members.
FINAL REPORT

1 BACKGROUND

In April 2012 the Parliamentary Crime and Misconduct Committee (the Committee) received a public interest disclosure\(^1\) alleging issues in relation to the conduct, regulation, registration and discipline of medical practitioners in Queensland. The Committee referred the content of the disclosure to the Crime and Misconduct Commission (CMC) for investigation.\(^2\)

The CMC appointed retired Supreme Court Judge, Mr Richard Chesterman AO RFD QC pursuant to section 256 of the *Crime and Misconduct Act 2001* (Qld) to undertake an independent assessment of the allegations and advise the CMC in relation to the allegations.\(^3\) Mr Chesterman’s report was provided to the Committee by the Chairperson of the CMC on 11 July 2012 and included four recommendations directed to the Minister for Health. Recommendation 2 states:\(^4\):

> “that there be a review of all the cases of misconduct or alleged misconduct by medical practitioners, dealt with by the QBMB or in which AHPRA has recommended disciplinary action against a medical practitioner, including cases in which the Notification Advisory Committee and/or QBMB rejected a recommendation by AHPRA to take disciplinary action. The review should be undertaken by a panel of three comprising a legal practitioner, a medical practitioner and someone who has served on regulatory boards and has a reputation for decisiveness. The purpose of the review should be to determine whether QBMB has made timely and appropriate responses to the complaints and recommendations, and whether it is achieving the objectives of the *Health Practitioners (Professional Standards) Act 1999*, set out in s 6, to protect the public, uphold standards of medical practice and maintain public confidence in the medical profession.”

In accordance with recommendation 2, the Minister for Health appointed the following persons to examine and review the files which came within the ambit of the recommendation:

- (a) Dr Kim Elizabeth Forrester;
- (b) Professor Elizabeth Anne Davies; and

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1 Ms Jo-Anna Barber made the public interest disclosure to Mr Rob Messenger (Member of the Legislative Assembly) under section 14 *Public Interest Disclosure Act 2010* (Qld).
2 As the Parliamentary Crime and Misconduct Committee has no jurisdiction to oversee or review the activities of other bodies other than the CMC (*Crime and Misconduct Act 2001* (Qld)).
3 1 May 2012.
Adjunct Professor James Henry Houston.

2 SCOPE OF THE REVIEW

The scope of the review was limited to the files of the Medical Board of Queensland (MBQ), the Queensland Board of the Medical Board of Australia (QB MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) where:

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3.2…

(b) (i) …the MBQ has started but not completed dealing with a complaint or notification against a medical practitioner prior to July 2010 and the matter had now been referred to QB MBA under the Health Practitioner Regulation National Law Act 2009; or

(ii) where the QB MBA has dealt with the matter or where AHPRA has recommended disciplinary action against a medical practitioner on or after 1July 2010.

(c) Subject to paragraph 3.2(b) …, the review will be of all files of MBQ/QB MBA and AHPRA where:

(i) a medical practitioner has engaged in misconduct or it was alleged in a complaint or notification that a medical practitioner had engaged in misconduct; and

(ii) the QB MBA has made a decision in relation to the complaint or notification about the medical practitioner (including those file where an interlocutory decision has been made to take action and that action is pending). For the avoidance of doubt, this will include a decision by the QB MBA (or delegate) to accept an undertaking in response to, or subsequent to, a complaint or notification about a medical practitioner.

‘Misconduct’ in relation to complaints initially dealt with prior to 1 July 2010 means “unsatisfactory professional conduct” as defined under the Health Practitioners (Professional Standards) Act 1999. That is:

(a) professional conduct that is of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner’s professional peers;

(b) professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practice of the practitioner’s profession;

(c) infamous conduct in a professional respect;

(d) misconduct in a professional respect;

(e) conduct discreditable to the practitioner’s profession;

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5 Schedule.
(f) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person’s wellbeing;

(g) influencing, or attempting to influence, the conduct of another practitioner in a way that may compromise patient care;

(h) fraudulent or dishonest behaviour in the practice;

(i) other improper or unethical conduct.

For notifications received after 1 July 2010 ‘misconduct’ means “professional misconduct”, “unprofessional conduct” or “unsatisfactory professional performance” defined under the Health Practitioner Regulation National Law Act 2009\(^7\) as:

**professional misconduct**, of a registered health practitioner, includes—

(a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner’s profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

**unprofessional conduct**, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner’s professional peers, and includes—

(a) a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and

(b) a contravention by the practitioner of—

   (i) a condition to which the practitioner’s registration was subject; or

   (ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and

(c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner’s suitability to continue to practise the profession; and

(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person’s well-being; and

(e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and

\(^7\) Section 5.
(f) accepting a benefit as inducement, consideration or reward for referring another
person to a health service provider or recommending another person use or consult
with a health service provider; and

(g) offering or giving a person a benefit, consideration or reward in return for the person
referring another person to the practitioner or recommending to another person that
the person use a health service provided by the practitioner; and

(h) referring a person to, or recommending that a person use or consult, another health
service provider, health service or health product if the practitioner has a pecuniary
interest in giving that referral or recommendation, unless the practitioner discloses
the nature of that interest to the person before or at the time of giving the referral or
recommendation.

unsatisfactory professional performance, of a registered health practitioner, means the
knowledge, skill or judgement possessed, or care exercised by the practitioner in the
practice of the health profession in which the practitioner is registered is below the
standard reasonably expected of a health practitioner of an equivalent level of training or
expertise.
3 PURPOSE OF THE REVIEW

The primary purpose of the review was to determine whether the MBQ/QBMBBA was achieving their primary objective of protecting the public through a process which ensured that medical practitioners were competent to practise. The express purpose was to determine whether the MBQ/QBMBBA was achieving the objectives of the *Health Practitioners (Professional Standards) Act 1999* as set out in s 6. The objectives include:

- protecting the public;
- upholding standards of medical practice; and
- maintaining public confidence in the medical profession.

Specifically the review panel (“panel”) was directed to form a view as to whether the QBMBBA had:

- made timely responses to complaints/notifications and recommendations made to it;
- made appropriate responses to complaints/notifications and recommendations made to it; and
- for those complaints initially dealt with prior to July 2010 and transferred to the QBMBBA, achieved the objectives of the *Health Practitioners (Professional Standards) Act 1999* as set out in s 6.

The review was to have particular regard to those matters where action was recommended by AHPRA, the Complaints Assessment Committee (CAC) or Notification Assessment Committee (NAC) and/or the Performance and Professional Standards Committee (PPSC) and no action was taken by the QBMBBA.
4 METHODOLOGY

4.1 File identification: Confirmation of Scope of the review

The identification of cases which were within the scope of the review was a difficult exercise. The panel is grateful to Ms Anne Morrison AHPRA (State Manager Qld), Dr Sue Sherrell, Ph.D. (Project Manager), Marc Corbet, Helen Davey, and the other staff at AHPRA for their effort in creating a data base that enabled us to select files that, at least initially, were deserving of further consideration. Files for review were selected according to the following inclusion criteria:

- Where the complaint about a medical practitioner had been received prior to the transition (1 July 2010) and remained open as of 1 July 2010. These were referred to as ‘legacy’ files;
- All complaints/notifications dealt with under the Health Practitioners (Professional Standards) Act 1999 opened after 1 July 2010. These are also referred to as ‘legacy files’;
- Where notifications to AHPRA, under the Health Practitioner Regulation National Law Act 2009, alleging misconduct by a medical practitioner, were received between 1 July 2010 and 30 June 2012, and the decision process included recommendations other than No Further Action (NFA). These were referred to as ‘non legacy’ files.

The spreadsheet of in-scope files raised and closed by Financial Year is illustrated in Table 4-1 and Figure 4-1.

<table>
<thead>
<tr>
<th>Closure of in-scope cases by financial year</th>
<th>Closed in FY 11</th>
<th>Closed in FY12</th>
<th>Closed after 30-Jun-12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>200</td>
<td>93</td>
<td>15</td>
<td>308</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPRNLA)</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 11</td>
<td>61</td>
<td>120</td>
<td>9</td>
<td>190</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 12</td>
<td>0</td>
<td>80</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>265</td>
<td>297</td>
<td>34</td>
<td>596</td>
</tr>
</tbody>
</table>

Table 4-1  Closure of in-scope files by financial year
Files excluded from the review were those where:

- Notifications which did not satisfy the legislative requirements for making a notification and were therefore not considered;
- AHPRA recommended No Further Action (NFA) and the NAC/QBMBBA accepted the recommendation;
- Notifications received after 1 July 2010 that are still open and where no sanctions have been imposed;
- Matters involving registration applications;
- Matters initially involving health ONLY or, at the time at which the basis for the complaint is determined to be health ONLY;
- Matters closed by the MBQ prior to 1 July 2010;
- Notifications received after 30 June 2012.
4.2 Process of the review

The members of the panel considered each file which came within the scope of the review. Individual complaints/notifications were recorded on spreadsheets according to their progression through the disciplinary process. Each file was examined and reviewed with respect to:

- Timeliness; and
- Appropriateness, which included compliance with legislative objectives.

There was a total of 2,451 files (those opened after 1 July 2010 in addition to the legacy files which transitioned across from the Medical Board on 1 July 2010) of which 596 were identified by the panel as being within the scope of the review. Of the 596 files, 308 were legacy files and 288 non-legacy. Table 4-2 Identifies all files in scope for the Chesterman Review by number closed in each financial year.

<table>
<thead>
<tr>
<th>Closure of in-scope cases by financial year</th>
<th>Closed in FY 11</th>
<th>Closed in FY12</th>
<th>Closed after 30-Jun-12</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>200</td>
<td>93</td>
<td>15</td>
<td>308</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPRNLNA)</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>HPRNLNA Notifications opened in FY 11</td>
<td>61</td>
<td>120</td>
<td>9</td>
<td>190</td>
</tr>
<tr>
<td>HPRNLNA Notifications opened in FY 12</td>
<td>0</td>
<td>80</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>265</strong></td>
<td><strong>297</strong></td>
<td><strong>34</strong></td>
<td><strong>596</strong></td>
</tr>
</tbody>
</table>

Table 4-2 Closure of in-scope cases by financial year

The 596 files were then individually reviewed from the perspectives of the timeliness and appropriateness of MBQ/QBMBBA’s disciplinary process and decisions. The panel considered that a total of 84 of the legacy files and 149 of the non-legacy files had been dealt with by the MBQ/QBMBBA in a timely and appropriate manner. These files, having been dealt with in an appropriate and timely manner, were therefore not examined any further by the panel. This left a total of 363 files comprising 224 legacy files and 139 non-legacy files remaining for further review by the panel. These files, known throughout the document as targeted files, were further reviewed to determine:

- Nature of the complaint/notification;
- Time from notification to first assessment and recommendation by OMBQ/AHPRA/CAC/NAC;
- Time taken from decision to appoint an investigator to the actual appointment of an investigator;
- Time taken to completion of the investigation;
- Time to closure;
- Congruence between AHPRA recommendation and MBQ/QBMBBA (or delegate) decision;
- Incidence and outcomes of Show Cause submissions;
• Incidence and outcomes of Investigations;
• Incidence of referral to Panel and/or Queensland Civil and Administrative Tribunal (QCAT);
• Appropriateness of QBMDA decisions in light of the nature/severity of the notification.
• Stage at closure and time taken;
• Outcome at point of closure;
• Incidence and outcomes of Immediate Action;
• Final outcomes of Board decisions.

Individual files were selected for examination in greater depth to clarify issues and better understand the processes in place. A number of these files were extracted as exemplars of the identified issues. The data identified and described in this report is specifically relevant to, and compliant with, the Terms of Reference as determined by Recommendation 2 of the Chesterman Report.
5 TIMELINESS

In relation to the issue of timeliness the legacy and non-legacy files were considered separately on the basis that the relevant legislation and agencies which directed the response to, and management of, the complaints/notifications changed on 1 July 2010 with the introduction of the National Scheme under the Health Practitioner Regulation National Law Act 2009. While the panel collected and examined information from the actual files of the individual practitioners and the original source documents, it was noted that since the introduction of the National Scheme the complaints/notifications are managed through Pivotal. Pivotal is the customer relationship management system introduced by AHPRA to process and manage notifications.

5.1 Legacy Files

5.1.1 Time from receiving a notification to OMBQ/AHPRA/CAC/NAC assessment

Of the 224 legacy files (being the 308 legacy files minus those treated in an appropriate and timely manner), 18 complaints had been received between 2005 and 2007, with the remaining 206 complaints received between 2008 and 2010. The length of time between the receipt of a complaint and an assessment meeting of the OMBQ/AHPRA/CAC/NAC ranged from the same day\(^8\) to 39 months\(^9\). Within this range there was considerable variability. The average time taken for a complaint to be brought before the first assessment meeting was 249 days. A further breakdown of time to the first assessment meeting is illustrated in Table 5-1.

<table>
<thead>
<tr>
<th>Time to first assessment meeting</th>
<th>&lt; 60 days</th>
<th>60-119 days</th>
<th>120-179 days</th>
<th>180-269 days</th>
<th>270-364 days</th>
<th>365-539 days</th>
<th>540-730 days</th>
<th>&gt; 2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>75</td>
<td>42</td>
<td>28</td>
<td>36</td>
<td>33</td>
<td>69</td>
<td>18</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 5-1 Breakdown of time from complaint received to first assessment meeting

The following files provide some (but not all) examples of the considerable delay in progressing clinically significant complaints to an OMBQ/AHPRA/CAC/NAC assessment meeting:

- Complaint regarding the outcome of a surgical procedure to repair a ventral hernia which resulted in lodgement of the small bowel in the initial surgical wound causing obstruction – 16 months\(^10\);
- Complaint that practitioner failed to diagnose monochorionic diamniotic twin pregnancy when reporting discordant growth on ultrasound result – 12 months\(^11\);

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\(^8\) Complaint/Notification CN310, Complaint/Notification CN307
\(^9\) Complaint/Notification CN71, Complaint/Notification CN72, Complaint/Notification CN73
\(^10\) Complaint/Notification CN199
\(^11\) Complaint/Notification CN78
• Notification from the Pharmacy Board of Australia regarding the prescription of Efexor for a patient that had resulted in hospitalisation of the patient and had occasioned disciplinary action against the dispensing pharmacists who had dispensed in accordance with prescriptions issued by the practitioner – 19 months\textsuperscript{12};

• Three complaints against a practitioner alleging performance of breast augmentation that resulted in post-operative infection and displacement (17 months)\textsuperscript{13}, re-constructive surgery resulting in facial disfigurement (16 months)\textsuperscript{14}, and excision of wrong lesion requiring additional surgery (20 months)\textsuperscript{15}.

The following provide some (but not all) examples of a lack of consistency and predictability in relation to the time which complaints of a similar nature took to be progressed to the OMBQ/AHPRA/CAC/NAC assessment meetings:

• A number of complaints involving post-operative complications following gastrointestinal surgery progressed through initial assessment across a broad time frame. For example, a complaint alleging perforation of the bowel during laproscopic surgery was assessed within one (1) month\textsuperscript{16} whereas an allegation of failure to follow up after surgery and “nicking” the duodenum during surgery, which required stitching, was assessed within six (6) months\textsuperscript{17}. Two (2) other complaints alleging serious post-operative complications following loop ileostomy and laproscopic hernia repair were presented at an assessment meeting after 13 months\textsuperscript{18} and 16 months\textsuperscript{19} respectively.

• Complaints regarding boundary violations of a sexual nature took varied times to reach an assessment meeting. Three complaints were assessed almost immediately. Each resulted in disciplinary action\textsuperscript{20}. A further six (6)\textsuperscript{21} were assessed between one (1) and three (3) months, resulting in four (4) disciplinary actions. All of the three (3) complaints assessed between four (4) and eight (8) months\textsuperscript{22} resulted in disciplinary action. Three complaints (3)\textsuperscript{23} were assessed between 12 and 14 months with one (1) resulting in disciplinary action.
5.1.2 Timeliness in appointing investigators and conducting investigations

The proportion of legacy files which proceeded to Investigation was 48%. Section 65 *Health Practitioners (Professional Standards) Act* 1999 imposes an obligation on the Board to:

“…ensure an investigation committee it establishes, or an investigator it directs to conduct an investigation, conducts the investigation as quickly as possible having regard to the nature of the matter to be investigated.”

5.1.2.1 Appointing investigators

In relation to the appointment of an investigator for legacy complaints, proceeding to investigation, the time ranged from two (2) days\(^{24}\) to 39 months (to appoint a second investigator)\(^{25}\). Within this range there was considerable variability. The average time taken to appoint an investigator was 86 days. A further breakdown of time to appointment is illustrated in Table 5-2 (the average time, and the times, identified in the table are reduced by 14 days to account for the time taken to confirm the Record of Decisions).

<table>
<thead>
<tr>
<th>Time to appoint the investigator</th>
<th>&lt; 46 days</th>
<th>46-105 days</th>
<th>106-165 days</th>
<th>166-255 days</th>
<th>256-350 days</th>
<th>351-525 days</th>
<th>18-24 mnths</th>
<th>&gt; 2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>84</td>
<td>40</td>
<td>8</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 5-2  Time to appoint an investigator

There were seven (7) instances in which the appointment of an investigator was made more than once for the same file following the decision to investigate. Two (2) of these files had investigators appointed three times at two (2), 11 and 15 months\(^{26}\) and 12 days, nine (9) months and 24 months\(^{27}\). The remaining six (6) files had an investigator appointed on two (2) occasions at one (1) month and 26 months\(^{28}\), six (6) months and 12 months\(^{29}\), six (6) months and 14 months\(^{30}\), one (1) month and 37 months\(^{31}\), three (3) days and 20 months\(^{32}\) and one (1) week and 39 months\(^{33}\).

Examples of files in which an investigator was appointed promptly included:

- Complaint regarding alleged misdiagnosis of musculoskeletal conditions – one (1) month\(^{34}\);

\(^{24}\) Complaint/Notification CN470, Complaint/Notification CN471

\(^{25}\) Complaint/Notification CN366, Complaint/Notification CN367, Complaint/Notification CN368

\(^{26}\) Complaint/Notification CN479

\(^{27}\) Complaint/Notification CN501

\(^{28}\) Complaint/Notification CN476

\(^{29}\) Complaint/Notification CN481

\(^{30}\) Complaint/Notification CN502

\(^{31}\) Complaint/Notification CN389

\(^{32}\) Complaint/Notification CN354

\(^{33}\) Complaint/Notification CN367, Complaint/Notification CN368

\(^{34}\) Complaint/Notification CN105, Complaint/Notification CN106
5.1.2.2 Conducting investigations

The length of time taken to conduct an investigation ranged from eight (8) days to 64 months. Within this range there was considerable variability. The average time taken to complete an investigation was 452 days. A further breakdown of time to investigation completion is illustrated in the Table 5-3.

<table>
<thead>
<tr>
<th>Legacy Cases (HPPSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
</tr>
</tbody>
</table>

Table 5-3 Time to conduct an investigation

There was a significant number of files in which the investigations took extremely long periods of time. Illustrative examples are listed below:

- 18 months – three (3) complaints against the same practitioner alleging inappropriate examination and treatment in addition to illegal prescribing;
- 19 months – prescribing a drug via telephone that, it was alleged, due to dosage and interaction with another medication, resulted in a hospital admission with a drug

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35 Complaint/Notification CN11, Complaint/Notification CN580, Complaint/Notification CN560
36 Complaint/Notification CN557, Complaint/Notification CN372, Complaint/Notification CN393,
Complaint/Notification CN449, Complaint/Notification CN450
37 Complaint/Notification CN28, Complaint/Notification CN29, Complaint/Notification CN30,
Complaint/Notification CN373
38 Complaint/Notification CN590
39 Complaint/Notification CN428
40 Complaint/Notification CN377
41 Complaint/Notification CN366
42 Complaint/Notification CN366, Complaint/Notification CN367, Complaint/Notification CN368
43 Complaint/Notification CN271
44 Complaint/Notification CN570, Complaint/Notification CN571, Complaint/Notification CN572
induced disease, neuroleptic malignant syndrome\textsuperscript{45}; alleged fraudulent entry of results of tests not performed entered into patient’s clinical notes, inadequate clinical records and inappropriate referral\textsuperscript{46};

- 20 months – allegations of intimidation, aggression and assault of work colleagues, concern regarding adequacy of clinical knowledge, skills and record keeping\textsuperscript{47};

- 25 months – prescription of S4 medications for patients whom the practitioner had not actually consulted with\textsuperscript{48};

- 26 months – complaint that practitioners failed to refer patient with symptoms that, on second opinion, proved to be ovarian cancer\textsuperscript{49};

- 27 months – complaint regarding a patient’s concern that the practitioner had not appropriately investigated and followed up a site where basal cell and squamous cell carcinomas had previously been removed\textsuperscript{50};

- 29 months – medical staff concerns regarding the practitioner’s clinical and surgical competence, medical knowledge base, communication skills and general integrity\textsuperscript{51}; concern whether the practitioner exhibited the appropriate skill, knowledge, judgement and care expected of a competent practitioner in cardiothoracic surgery and whether their conduct was of a lesser standard than expected\textsuperscript{52};

- 32 months – complaint regarding the practitioner’s clinical management of patients including allegations of inappropriate prescribing of thrombolytic medication, delayed diagnosis of bioprosthetic valve endocarditis despite positive blood culture on admission, and an adverse drug reaction arising from the practitioner’s clinical management\textsuperscript{53};

- 34 months – OMBQ initiated an investigation into a practitioner’s supervision and “satisfactory” supervisor’s reports of another practitioner who had been found to have engaged in unprofessional conduct when he failed to adequately treat patients due to undertaking excessive numbers of daily consultations\textsuperscript{54};

- 35 months – alleged inappropriate touching of a patient during a house visit\textsuperscript{55};

\textsuperscript{45} Complaint/Notification CN104
\textsuperscript{46} Complaint/Notification CN203
\textsuperscript{47} Complaint/Notification CN375
\textsuperscript{48} Complaint/Notification CN287
\textsuperscript{49} Complaint/Notification CN476
\textsuperscript{50} Complaint/Notification CN107
\textsuperscript{51} Complaint/Notification CN11
\textsuperscript{52} Complaint/Notification CN580
\textsuperscript{53} Complaint/Notification CN354
\textsuperscript{54} Complaint/Notification CN307
\textsuperscript{55} Complaint/Notification CN372
• 40 months – allegations regarding the practitioner’s unnecessary administration of iron infusions to patients who did not appear to have signs of iron deficiency. Administration of these infusions in a general practice rather than a hospital setting, and whether the patients were providing a legally valid informed consent before receiving treatment;  

• 41 months – allegation that the practitioner displayed threatening and abusive behaviour when attempting to administer medication to a child with Asperger’s Syndrome and had written prescriptions in the complainant’s name of which she had no knowledge;  

• 44 months – concerns raised by experienced medical staff regarding the safety of the practitioner’s surgical techniques;  

• 64 months – allegations from medical colleagues that the practitioner continued to practise in an unorthodox and unconventional manner.

5.2 Non-legacy Files

5.2.1 Time from receiving a notification to AHPRA/NAC assessment

Section 149 Health Practitioner Regulation National Law Act 2009:

(1) “A National Board must, within 60 days after receipt of a notification, conduct a preliminary assessment of the notification…”

The lengths of time between receiving a notification, and an assessment meeting of the AHPRA/NAC are detailed below. The date of receipt of a notification was the date on which notification was received by AHPRA as set out under section 146 of the Health Practitioner Regulation National Law Act 2009. It is of note that the average time measurements for notifications opened in 2011 and 2012 will decrease as the data do not include open notifications which, when closed in future years will increase the average time.

• Notifications received in 2010 – seven (7) days to nine (9) months (of the 69 in-scope files for review);  

• Notifications received in 2011 – the same day to 15 months (of the 63 in-scope files for review);  

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56 Complaint/Notification CN168  
57 Complaint/Notification CN551  
58 Complaint/Notification CN280  
59 Complaint/Notification CN272  
60 Complaint/Notification CN505  
61 Complaint/Notification CN37  
63 Complaint/Notification CN487 Notification March 2011 – assessment meeting June 2012
Notifications received in 2012 – one (1) month\(^{64}\) to four (4) months\(^{65}\) (of the 2 in-scope files for review). It is to be noted that there were another 120 files opened from 1 January 2012 but categorised as “out of scope” on the basis that they were still open as of 30 June 2012. Of the nine (9) files that were in scope, seven (7) were dealt with in an appropriate and timely manner.

Within the ranges quoted above there was considerable variability. The average time taken to be brought before the first assessment meeting was 105 days in Financial Year 2011. A further breakdown of time to the first assessment meeting is illustrated in Table 5-4.

<table>
<thead>
<tr>
<th>Time to first assessment meeting</th>
<th>&lt; 60 days</th>
<th>60-119 days</th>
<th>120-179 days</th>
<th>180-269 days</th>
<th>270-364 days</th>
<th>365-539 days</th>
<th>540-730 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notifications opened prior to FY11 (HPRNLA)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 11</td>
<td>76</td>
<td>59</td>
<td>30</td>
<td>11</td>
<td>0</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 12</td>
<td>47</td>
<td>32</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 5-4  Breakdown of time from notification received to first assessment meeting

The significant variation in the lengths of time that notifications remained in this preliminary stage of the process (between notification and assessment meeting) did not appear to be correlated with the nature or seriousness of the notification, a history of prior or similar complaints/notifications about the practitioner, and/or the source of the notification.

The delay at this stage of the process results in practitioners, who potentially pose a risk of harm to the public, continuing to practise in this interim period. The length of time from receiving a notification to assessment by AHPRA/NAC is particularly relevant when the practitioners continue to practise with no conditions, undertakings, supervision or monitoring of their competency. In a number of the files the practitioners were working as sole practitioners and/or in the general practice sector where there was no mentoring or supervisory framework to monitor their competency to practise. The following files provide some (but not all) examples of the considerable delay in progressing clinically significant notifications to an AHPRA/NAC assessment meeting:

**Notifications received in 2010**

- Notification alleging the practitioner was continuing to prescribe Dexamphetamine for an adolescent patient who was suffering from suicidal ideation, and an eating disorder, despite the patient experiencing severe weight loss - three (3) months\(^{66}\);

- Notification that the practitioner misdiagnosed a patient as having a migraine, administered an injection of Morphine and then advised the patient that “it would be good” for the patient to drive a motor vehicle. The patient was subsequently diagnosed as having a subdural haematoma - five (5) months\(^{67}\);

\(^{64}\) Complaint/Notification CN39 Notification January 2012 – assessment meeting February 2012

\(^{65}\) Complaint/Notification CN100 Notification February 2012 – assessment meeting May 2012

\(^{66}\) Complaint/Notification CN57 Notification December 2010 – assessment meeting March 11

\(^{67}\) Complaint/Notification CN388 Notification October 2010 – assessment meeting March 2011
• Notification alleging the practitioner had failed to report a mass, evident on CT scan, which resulted in a delay in diagnosis and treatment of a patient – five (5) months 68;

• Notification alleging the practitioner had failed to diagnose a patient whose blood tests evidenced positive tumour markers – six (6) months 69;

• Notification that the practitioner inadequately coordinated medical care including prescribing medications to which the patient had an allergy and which adversely reacted with the patient’s other medications – seven (7) months 70.

The following provides some (but not all) examples of a lack of consistency and predictability in relation to the time which notifications of a similar nature took to be progressed to the AHPRA/NAC assessment meetings:

• A notification alleging the practitioner had engaged in unsafe prescribing practices over approximately three and half (3½) years was brought before the AHPRA/NAC assessment meeting in 16 days 71. A similar notification however, alleging inappropriate prescribing of Pseudoephedrine over a period of 16 months, took six (6) months before it was considered by the AHPRA/NAC meeting 72. In relation to another notification, involving the “inappropriate prescribing of narcotics”, the notification came before the assessment meeting in one (1) month. In this case the practitioner had been the subject of two (2) previous complaints about his prescribing practices 73. In another notification involving prescribing and administration of drugs, in which it was alleged the practitioner was administering ozone injections to a patient (considered as “unconventional medical practice”), the matter did not come before the assessment meeting for five (5) months 74;

• Notifications involving a failure to adequately assess and diagnose patients variously took one (1) month 75 (where it was alleged the practitioner failed to diagnose a pregnancy before administering an injection of Depo Provera), three (3) months 76 (where it was alleged the practitioner “failed to adequately assess and diagnose the patient’s symptomology which subsequently led to the patient’s death…did not tell the patient to go to hospital if the pain got worse…denied knowledge of the patient when contacted by police and would not sign the death certificate”), four (4) months 77 (where it was alleged the practitioner ignored the patient’s symptoms, failed to conduct a rectal

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68 Complaint/Notification CN135 Notification November 2010 – assessment meeting April 2011
69 Complaint/Notification CN23 Notification November 2010 – assessment meeting April 2011
71 Complaint/Notification CN264 Notification September 2010 – assessment meeting September 2010.
73 Complaint/Notification CN504 Notification August 2010 – assessment meeting September 2010.
74 Complaint/Notification CN27 Notification September 2010 – assessment meeting February 2011.
75 Complaint/Notification CN24 Notification December 2010 – assessment meeting January 2011
76 Complaint/Notification CN51 Notification July 2010 – assessment meeting October 2011.
77 Complaint/Notification CN177 Notification October 2010 – assessment meeting February 2011.
examination and incorrectly diagnosed chronic prostatitis when the patient had prostate cancer), six (6) months\(^78\) (where it was alleged the practitioner did not correctly interpret the blood results of a patient who was later diagnosed with, and died from, advanced pancreatic cancer) and seven (7) months\(^79\) (where the patient alleged the practitioners had misdiagnosed and wrongly treated a respiratory condition);

- Notifications based on allegations of poor standards of medical care and treatment varied considerably with one (1) matter taking only 17 days\(^80\) and others taking up to five (5)\(^81\) and six (6) months\(^82\);

- Notifications involving the communication styles of medical practitioners described as “rude” or “dismissive”, “aggressive” and/or “belittling” variously took between three (3)\(^83\) and nine (9)\(^84\) months to progress from notification to a AHPRA/NAC assessment meeting. In the latter example, the nine (9) month time delay between notification and AHPRA/NAC assessment meeting was despite the fact that the practitioner was recorded as having had 34 previous complaints and notifications received by the Health Quality and Complaints Commission (HQCC)\(^85\) and “9 previous contacts with the Board with the vast majority of them in relation to communication issues”\(^86\) (sic).

**Notifications received in 2011:**

As previously stated, the delay between AHPRA receiving a notification, and the assessment of that notification by the AHPRA/NAC, potentially places the public at risk of harm for the period when the practitioner (the subject of the notification) continues to practise. The following are some (but not all) examples of substantial periods of delay between receiving clinically significant notifications and the allegations contained in the notification coming before the AHPRA/NAC assessment meetings:

\(^78\) Complaint/Notification CN23 Notification November 2010 – assessment meeting April 2011
\(^79\) Complaint/Notification CN6 Notification November 2010 – assessment meeting May 2011,
\(^80\) Complaint/Notification CN7 Notification November 2010 – assessment meeting May 2011
\(^81\) Complaint/Notification CN167 where it was alleged the practitioner admitted a patient to a palliative care unit after a referral for an increased white cell count. Notification July 2010 – assessment meeting July 2010
\(^82\) Complaint/Notification CN339, Notification September 2010 – assessment meeting February 2011 (notification from the Coroner involving a failure of the practitioner to provide adequate care)
\(^83\) Complaint/Notification CN8 Notification August 2010 – assessment meeting February 2011 (allegation that the practitioner refused the patient’s request for medications for a failed pregnancy, conducted a dilation and curette during which the patient’s uterus was perforated for which she required a laparotomy)
\(^84\) Complaint/Notification CN129 Notification 26 November 2010 – assessment meeting 6 February 2011
\(^85\) Complaint/Notification CN37 Notification 20 October 2010 – assessment meeting 16 July 2011
\(^86\) Queensland Board of the Medical Board of Australia, Agenda Papers dated 25.10.11
• Notification alleging the failure by the practitioner to recognise both, the incorrect report of “gallbladder calculus” in a urinary tract ultrasound and, note the patient’s clinical presentation was not indicative of gallstones. The misdiagnosis of the patient’s condition, subsequent delay in appropriate treatment and failure to keep complete and comprehensive clinical notes – 12 months\textsuperscript{87};

• Notification alleging inappropriate touching of a patient by the medical practitioner – 15 months\textsuperscript{88};

• Notification alleging the practitioner administered a single injection of a desensitising vaccine, at eight (8) times the recommended dose which resulted in ongoing side effects – eight (8) months\textsuperscript{89};

• Notification alleging that the supervising surgeon was not present in the operating theatre when a “trainee surgeon” performed an orchidectomy. The patient allegedly sustained significant and ongoing complications resulting from the surgery – seven (7) months\textsuperscript{90}.

The following provides some (but not all) examples of a lack of consistency and predictability in relation to the time which notifications of a similar nature took to be progressed to the AHPRA/NAC assessment meetings:

• Notifications based on allegations of prescribing and administering drugs and poisons were bought before the assessment meeting after varying periods of time. A notification that a child had been administered an incorrect dose of a medication resulting in an adverse outcome was brought before the assessment meeting in 14 days\textsuperscript{91} whereas an allegation that the patient was given an inappropriate mix of drugs which resulted in death was six (6) months before it progressed to the assessment meeting\textsuperscript{92}. An allegation that a practitioner was prescribing drugs in contravention of the conditions of his registration came before the assessment meeting after six (6) weeks\textsuperscript{93};

• Notifications based on a practitioner’s failure to adequately assess and diagnose took anywhere between one (1)\textsuperscript{94} month (an alleged failure by a practitioner to diagnose a transient ischaemic attack; an allegation of misdiagnosis of ectopic pregnancy) and 11 months \textsuperscript{95}(where the allegations included the practitioner had failed to appropriately
assess mammogram and ultrasound results which led to a delay in diagnosis and treatment of a patient’s cancer). In a notification alleging a practitioner had failed to diagnose pre-eclampsia which may have contributed to a stillbirth and placed the patient’s life at risk it took two (2) months before the matter was considered at the assessment meeting and five (5) months in relation to a notification that the practitioner had failed to act on a child’s symptoms and blood results which indicated he was suffering from significant hypercalcaemia.

• Notifications based on a poor standard of medical practice and/or adverse surgical outcomes took between one (1) and five (5) months to come before the assessment meeting;

• Notifications alleging various degrees and forms of boundary violations took between three (3) months (the practitioner was exhibiting excessive affectionate behaviour to female patients) and 15 months (inappropriate touching of a female patient by a practitioner). A notification alleging the practitioner inappropriately touched, and attempted to develop an inappropriate relationship with, a patient came before the assessment meeting after 10 months and a notification alleging the practitioner attempted to manipulate an 82 year old patient to obtain the patient’s home took four (4) months.

Notifications received in 2012:

In relation to the files reviewed in the year 2012 there were 120 files open which were therefore out of scope. Of the nine (9) files in scope, seven (7) were dealt with in a timely and appropriate manner. The two notifications, which each involved prescribing practices, came before the assessment meeting after one (1) month (where the allegations involved prescribing prednisone over a two (2) year period and the subsequent symptoms suffered by the patient) and four (4) months (for a notification alleging the practitioner was prescribing Section 100 antiretroviral medications despite the practitioner not having the requisite approval).

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96 Complaint/Notification CN469 Notification January 2011 – assessment meeting June 2011.
98 Complaint/Notification CN399 – failure to provide appropriate care during a hospital admission: Notification January 2011 – assessment meeting June 2011, Complaint/Notification CN422 – declining hand/eye coordination, outdated medical practices and the death of a patient following the administration of a medication to the patient: Notification December 2011 – assessment meeting April 2012.
99 Complaint/Notification CN300 Notification October 2011 – assessment meeting January 2012.
100 Complaint/Notification CN487 Notification March 2011 – assessment meeting June 2012.
101 Complaint/Notification CN250 notification January 2011 – assessment meeting October 2011
5.2.2 Timeliness in appointing investigators and conducting investigations

Once the AHPRA/NAC assessment was completed, a decision was made as to which of the notifications would be progressed to investigation. The proportion of non-legacy files reaching investigation was 26%. However, it should be noted that many of the complex non-legacy files are still open and therefore out of scope. While the Health Practitioner Regulation National Law Act 2009 is silent as to the timeframe for the appointment of an investigator, section 162 prescribes that the National Board:

“...ensures an investigator it directs to conduct an investigation conducts the investigation as quickly as practicable, having regard to the nature of the matter to be investigated.” (emphasis added)

5.2.2.1 Appointing investigators

The lengths of time taken to appoint investigators and conduct investigations varied considerably and, in many of the files, did not appear to be pre-determined by either the nature or seriousness of the notification. The average time taken to appoint an investigator for notifications raised in Financial Year 2011 was 72 days. A further breakdown of time to appointment is illustrated in Table 5-5 (the average time, and the times identified in the table are reduced by 14 days to account for the time taken to confirm the Record of Decisions).

<table>
<thead>
<tr>
<th>Time to appoint the investigator</th>
<th>&lt; 46 days</th>
<th>46-105 days</th>
<th>106-165 days</th>
<th>166-255 days</th>
<th>256-350 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notifications opened prior to FY11 (HPRNLA)</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 11</td>
<td>24</td>
<td>18</td>
<td>13</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 12</td>
<td>20</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 5-5 Time to appoint an investigator

In relation to the appointment of an investigator, for those notifications received in 2010, 2011 and 2012 (up to 30 June 2012) the time ranged from a same day appointment of an investigator \(^{103}\) through to 14\(^{104}\) months for an appointment to be made. As the appointment of an investigator (based on the documents available) is an administrative part of the disciplinary process it was unclear as to why there was such a difference in the time period taken for the appointment between the files and why, in some files, this process took such a long period of time. Part of the explanation for the length of time may lie in the convoluted process which requires:

- A decision to investigate made at the NAC meeting;
- Confirm Record of Decisions two weeks later;
- Board Support sends Record of Decisions to Program Support;
- Pivotal update by Program Support;

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\(^{103}\) Complaint/Notification CN259.
\(^{104}\) Complaint/Notification CN504.
• Program Support sends Record of Decisions to Assistant Manager, Notifications who assigns an investigator;

• Investigation Support Officer updates Pivotal with allocated investigator;

• Investigation Support Officer creates ‘Direction to investigate’ notice which is signed by Director, Notifications.

In addition, as occurred in the legacy files, there were a number of non-legacy investigations that were delayed by the necessity to appoint new investigators to replace investigators who left part-way through an investigation.

Notifications received in 2010

The variations in time taken to appoint an investigator ranged from one (1) month\(^{105}\) to 14 months\(^{106}\) (where the allegations involved the inappropriate prescribing of Schedule 8 drugs). The files in which the appointment of investigators occurred one (1) month after the AHPRA/NAC decision, involved clinically significant allegations as evident in the following:

• Failure to review or action abnormal histopathology results positive for Adenocarcinoma, failure to inform patient, failure to coordinate treatment\(^{107}\);  

• Failure to review or action abnormal histopathology results positive for Adenocarcinoma which contributed to a three (3) year delay in treatment, concealing knowledge of the pathology results\(^{108}\);  

• Failure to provide an adequate level of care during a consultation after which the patient died on the following day\(^{109}\);  

• Unsafe prescribing practices\(^{110}\);  

• Failure to provide appropriate post-operative care\(^{111}\);


\(^{106}\) Complaint/Notification CN504, Complaint/Notification CN503, Complaint/Notification CN505 A decision was made to appoint an investigator in September 2010 in response to notifications received in July, August and September 2010 however, an investigator was not appointed initially until March 2011 (6 months after the September 2010 notification) and then again in November 2011 (14 months after the September 2010 notification).  

\(^{107}\) Complaint/Notification CN221  

\(^{108}\) Complaint/Notification CN458  

\(^{109}\) Complaint/Notification CN339  

\(^{110}\) Complaint/Notification CN264  

\(^{111}\) Complaint/Notification CN264
• Failure to obtain an adequate clinical history, conduct an appropriate examination, record and understand the significance of test results, refer to a specialist for review, or diagnose prostate cancer\textsuperscript{112};

• Failure to recognise significant symptoms, conduct an appropriate examination or make a correct diagnosis\textsuperscript{113}.

However a number of other notifications, considered by the AHPRA/NAC as significant enough to require investigation, were not dealt with as promptly:

• Notifications based on unsafe prescribing practices, the time taken to appoint an investigator was inappropriately lengthy given the clinical nature and significance of the allegations. As an example, an investigator was not appointed for three (3) months after the AHPRA/NAC decisions to investigate in relation to a notification that a practitioner was administering ozone injections to a patient who suffered a reaction to a salve prescribed for cancer\textsuperscript{114};

• Notifications based on allegations of poor standards of medical practice, poor surgical outcomes and failure of practitioners to diagnose were held in abeyance for seven (7)\textsuperscript{115}, five (5)\textsuperscript{116}, four (4)\textsuperscript{117} and three (3)\textsuperscript{118} months awaiting the appointment of an investigator.

Notifications received in 2011

The variations in times taken to appoint an investigator ranged from an appointment made on the same day as the AHPRA/NAC assessment meeting decision (when the practitioner was currently under investigation for an unrelated notification)\textsuperscript{119} to 10 months\textsuperscript{120} (where the notification involved an allegation that the practitioner had failed to provide appropriate care by not seeing the patient during their period of hospitalisation). Of the notifications within scope, where the decision was made to appoint an investigator this occurred, in the majority of files, within one

\textsuperscript{112} Complaint/Notification CN196
\textsuperscript{113} Complaint/Notification CN177
\textsuperscript{114} Complaint/Notification CN27 Assessment meeting September 2010 – investigator appointed February 2011.
\textsuperscript{115} Complaint/Notification CN266 Assessment meeting December 2010 – investigator appointed July 2011.
\textsuperscript{116} Complaint/Notification CN167 Assessment meeting July 2010 – investigator appointed December 2010, Complaint/Notification CN564 Assessment meeting November 2010 – investigator appointed April 2011, Complaint/Notification CN191 Assessment meeting February 2011 – investigator appointed July 2011,
\textsuperscript{117} Complaint/Notification CN218 Assessment meeting February 2011 – investigator appointed July 2011,
Complaint/Notification CN431 Assessment meeting November 2010 – investigator appointed April 2011.
\textsuperscript{118} Complaint/Notification CN322 Assessment meeting March 2011 – investigator appointed July 2011,
Complaint/Notification CN124 Assessment meeting March 2011 – investigator appointed July 2011,
\textsuperscript{119} Complaint/Notification CN257 assessment meeting March 2011 – investigator appointed June 2011, Complaint/Notification CN23 Assessment meeting April 2011 – investigator appointed July 2011.
\textsuperscript{120} Complaint/Notification CN259: The practitioner had been the subject of a previous complaint in relation to different allegations and was under investigation in relation to the initial notification from 21.6.2011 to 24.1.2012. The investigation into this notification commenced on 9.8.2011 and was completed on 23.3.2012.
(1) to five (5) months and it was difficult to ascertain consistency in the time taken to appoint in relation to the nature or significance of the allegations. The following are examples of the nature of some (but not all) the matters investigated and the time taken to appoint an investigator:

- **1 month:** For notifications variously alleging: surgical complication involving a cut tendon during surgery to relieve a carpal tunnel compounded by a failure of the practitioner to diagnose \(^{121}\), inappropriate post-operative care and treatment \(^{122}\), a practitioner self-medicating, behaving inappropriately and being excessively affectionate to female patients \(^{123}\);

- **2 months:** For notifications variously alleging the failure of a practitioner to diagnoses the patient’s pre-eclampsia prior to a still birth \(^{124}\), the attempt by a practitioner to manipulate an 82 year old patient for the purpose of obtaining her house \(^{125}\);

- **4 months:** In relation to notifications alleging a surgeon had discharged a patient post-operatively when there was an infection present and no antibiotics had been prescribed \(^{126}\), a surgeon whose accreditation at a private hospital had been suspended “indefinitely” following a number of cases resulting in “significant adverse surgical outcomes” \(^{127}\);

- **5 months:** In a notification alleging that the practitioner was “intoxicated” while treating patients \(^{128}\). It is of note, in relation to this particular practitioner, that there had been five (5) prior notifications which extended back to May 2009 and the practitioner had been under investigation by investigators appointed in November 2009 and August 2010 \(^{129}\).

### 5.2.2.2 Conducting investigations

The length of time taken to conduct an investigation (appointment of investigator to completion of the investigation) was, in many of the files, determined by the clinical complexity of the allegations as contained in the notifications. The average time taken to complete an investigation in Financial Year 2011 was 240 days. A further breakdown of the length of time to investigation completion is illustrated in Table 5-6.

<table>
<thead>
<tr>
<th>Time to conduct an investigation</th>
<th>&lt; 60 days</th>
<th>60-119 days</th>
<th>120-179 days</th>
<th>180-269 days</th>
<th>270-364 days</th>
<th>365-539 days</th>
<th>540-730 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRNLA Notifications opened prior to FY11</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 11</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>16</td>
<td>8</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 12</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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\(^{121}\) Complaint/Notification CN277

\(^{122}\) Complaint/Notification CN401

\(^{123}\) Complaint/Notification CN300

\(^{124}\) Complaint/Notification CN33

\(^{125}\) Complaint/Notification CN295

\(^{126}\) Complaint/Notification CN242

\(^{127}\) Complaint/Notification CN69

\(^{128}\) Complaint/Notification CN506

\(^{129}\) Allegations in relation to these prior notifications included: inappropriate and fraudulent prescribing (anabolic steroids, narcotics), inappropriate relationships with female patients and inappropriate record keeping,
Table 5-6  Time to conduct an investigation

The times taken ranged between:

- one (1) month\textsuperscript{130}, where the patient alleged the surgeon was not able to be contacted post-operatively when it was discovered “that her uterine artery had been nicked and an intra-abdominal haematoma of approximately two litres had formed in her abdomen” requiring emergency surgery; and

- 15 months\textsuperscript{131} in relation to a notification that a practitioner had failed to review or take action in relation to a “patient’s abnormal histopathology result, which was positive for adenocarcinoma… (and) had attempted to later conceal the histopathology result”\textsuperscript{132}.

Notifications received in 2010

It was evident from the files that a number of the notifications which went to investigation, and remained under investigation for prolonged periods of time, were not clinically complicated in respect of the nature of the allegations to be investigated. The following files illustrate a number (but not all) of the notifications in which the investigations were not conducted in a timely way. That is, it did not appear that they were investigated “as quickly as practicable, having regard to the nature of the matter to be investigated”\textsuperscript{133}:

- 10 months: The notification alleged the surgeon, in relation to one (1) patient at one (1) facility, performed a circumcision at a standard below that reasonably expected, that the practitioner was not available by phone when the post-operative bleeding commenced, failed to obtain appropriate consent, failed to provide adequate postoperative advice, failed to keep adequately detailed medical records, practised solo in breach of his registration conditions and billed Medicare twice for the one (1) service. It is of particular note that the investigator was aware of admissions by the practitioner as to the allegations two months after the investigation commenced\textsuperscript{134} being eight (8) months before completion;

- 10 months: The notification alleged the practitioner discharged a patient who was experiencing significant bleeding from an inevitable and incomplete miscarriage\textsuperscript{135}. This matter took 15 months from the time the decision was made to investigate to the completion of the investigation;

\textsuperscript{130} Complaint/Notification CN538: February 2012-March 2012.
\textsuperscript{131} Complaint/Notification CN458: March 2011- May 2012.
\textsuperscript{132} Complaint/Notification CN458: Agenda Papers Performance and Professional Standards Committee, 2 June 2012.
\textsuperscript{133} Health Practitioner Regulation National Law Act section 162 (emphasis added).
\textsuperscript{134} Complaint/Notification CN149 Board minutes 24 January 2012.
\textsuperscript{135} Complaint/Notification CN564
10 months: The notification alleged severe post-surgical complications\textsuperscript{136}. It is noted that the investigator did not seek an expert opinion report until five (5) months after the investigation was commenced and the report took two (2) months to be completed and returned (7 months after the investigator was appointed)\textsuperscript{137}. This matter took 15 months from the time the decision was made to investigate to the completion of the investigation;

13 months: The allegations were that the patient requested Misoprostol for a failed pregnancy. The practitioner refused to prescribe the medication and instead conducted a dilation and curette during which the patient’s uterus was perforated. The patient required a laparotomy\textsuperscript{138}. This matter took 15 months from the time the decision was made to investigate to the completion of the investigation;

13 months: The notification alleged a teenage patient (diagnosed with an eating disorder and suicidal ideation) had been prescribed Dexamphetamine despite her continued weight loss\textsuperscript{139}. This matter took 15 months from the date the decision was made to investigate to the completion of the investigation;

13 months: Allegations of poor post-operative care and treatment in relation to one (1) patient\textsuperscript{140};

14 months: Notification alleging that the surgeon was not able to be contacted when the patient deteriorated post-operatively. Other practitioners were required to undertake surgery to control on-going bleeding\textsuperscript{141}. This matter took 16 months from the date the decision was made to investigate to the completion of the investigation;

16 months: The allegations, as contained in the notification, included that the practitioner had ignored symptoms, failed to conduct a rectal examination and made an incorrect diagnosis in relation to one (1) patient. This resulted, it was alleged, in a delay in diagnosis by which time the cancer had metastasised\textsuperscript{142}. It was noted that the investigator experienced “difficulty finding a suitably qualified urologist to provide a peer opinion report”.

\textit{Notifications received in 2011}

The length of time taken to investigate a notification (appointment of investigator to completion of the investigation) ranged between one (1)\textsuperscript{143} and nine (9) months\textsuperscript{144}. While the nature and

\begin{footnotesize}
\begin{enumerate}
  \item Complaint/Notification CN191
  \item Performance and Professional Standards Committee: meeting date 22 May 2012, \textit{Investigation Report}
  \item Complaint/Notification CN8
  \item Complaint/Notification CN57
  \item Complaint/Notification CN400
  \item Complaint/Notification CN116
  \item Complaint/Notification CN177
  \item Complaint/Notification CN399
  \item Complaint/Notification CN242
\end{enumerate}
\end{footnotesize}
The complexity of the allegations in some files determined the length of time taken to investigate there were a number of notifications which did not appear to warrant the significant length of time from appointment to completion. The following evidence some (but not all) of the investigations into uncomplicated allegations which took several months to investigate and added to the already long period of time which had passed since the initial notification was received:

- 9 months: The notification alleged the patient had experienced post-operative wound infections while still an in-patient and had been discharged from the hospital by the practitioner with “oozing and gaping holes” and not prescribed antibiotics. It is of note that there was four (4) months between the decision to appoint an investigator and the actual appointment in addition to the nine (9) months to complete the investigation. At the time of completion of the investigation it had been 14 months since the date of the notification;

- 7 months: The notification alleged that the practitioner had failed to diagnose a variation of pre-eclampsia (in a patient who was 37 weeks pregnant) which contributed to a stillbirth and placed the patient at risk.145 The date of completion of the investigation was 11 months after receiving the notification;

- 7 months: Allegation of inappropriate post-operative treatment. The date of completion of the investigation being nine (9) months after receiving the notification146;

- 7 months: The allegations in the notification involved adverse surgical outcomes and a decision by the private hospital to suspend the practitioner’s accreditation “indefinitely”. The date of completion of the investigation being twelve (12) months after receiving the notification147.

Notifications received in 2012

Of the nine (9) files in scope, seven (7) were dealt with in a timely and appropriate manner. The remaining two (2) notifications were not investigated.

5.3 Time from notification to final decision

The average time taken to reach a final decision for legacy complaints was 585 days and the time taken to reach a final decision for notifications raised in Financial Year 2011 was 288 days. A further breakdown of time to reach a final decision is illustrated in Table 5-7.

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146 Complaint/Notification CN401
147 Complaint/Notification CN69
<table>
<thead>
<tr>
<th>Time to make final decision</th>
<th>&lt; 60 days</th>
<th>60-119 days</th>
<th>120-179 days</th>
<th>180-269 days</th>
<th>270-364 days</th>
<th>365-539 days</th>
<th>540-730 days</th>
<th>&gt; 2 years</th>
<th>Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>7</td>
<td>16</td>
<td>9</td>
<td>29</td>
<td>26</td>
<td>69</td>
<td>62</td>
<td>83</td>
<td>7</td>
</tr>
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<td>Notifications opened prior to FY11 (HPRNLA)</td>
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<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 11</td>
<td>12</td>
<td>25</td>
<td>19</td>
<td>38</td>
<td>28</td>
<td>47</td>
<td>16</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 12</td>
<td>13</td>
<td>20</td>
<td>12</td>
<td>34</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 5-7 Time from notification to final decision
Legacy notifications

The time from notification to a final decision by the Board ranged from 36 days\(^{148}\) to 2,368 days\(^{149}\).

Notifications received in 2010

The time from notification to a final decision by the Board ranged from 113 days\(^{150}\) to 643 days\(^{151}\).

Notifications received in 2011

The time from notification to a final decision by the Board ranged from 110 days\(^{152}\) to 635 days\(^{153}\).

Notifications received in 2012

The time from notification to a final decision by the Board ranged from 137 days\(^{154}\) to 215 days\(^{155}\).

It is of note that the average time measurements for notifications opened in 2011 and 2012 will decrease as the data does not include open notifications which, when closed in future years, will increase the average time.

5.4 Specific issues in relation to timeliness

The following issues were identified by the panel as significantly affecting the length of time taken from receiving a complaint/notification to a final decision.

5.4.1 Immediate Action

Section 156 Health Practitioner Regulation National Law Act 2009 empowers the Board to take “immediate action”\(^{156}\) in relation to a practitioner if:

“(1)(a) A National Board reasonably believes that-

(i) because of the registered health practitioner’s conduct, performance or health, the practitioner poses a serious risk to persons; and

\(^{148}\) Complaint/Notification CN230  
\(^{149}\) Complaint/Notification CN361  
\(^{150}\) Complaint/Notification CN321  
\(^{151}\) Complaint/Notification CN8  
\(^{152}\) Complaint/Notification CN292  
\(^{153}\) Complaint/Notification CN399  
\(^{154}\) Complaint/Notification CN100  
\(^{155}\) Complaint/Notification CN39  
\(^{156}\) “immediate action” under section 155 Health Practitioner Regulation National Law Act is defined to mean suspension, the imposition of a condition, accepting an undertaking or accepting the surrender of the health practitioner’s registration.
(ii) it is necessary to take immediate action to protect public health or safety…”

(2) …the National Board may take immediate action that consists of suspending, or imposing a condition on, the health practitioner…only if the Board has complied with section 157

Section 157 (1) requires the Board, if proposing to take immediate action under section 156 must:

“(a) give the practitioner…notice of the proposed immediate action; and
(b) invite the practitioner …to make a submission to the Board, within the time stated in the notice about the immediate action.”

It was noted by the panel that the ‘immediate action’ response to notifications about practitioners was infrequently utilised (as evident in the data below) in relation to the in-scope files reviewed by the panel. Of concern to the panel is the actual process, as prescribed by the legislation, which hampers rather than facilitates the taking of ‘immediate action’ on receipt of a notification about a practitioner who is potentially an immediate and significant risk to the public. The provision, which requires the Board to give notice of the ‘immediate action’ and then invite a submission from the practitioner before action can be taken, results in the practitioner continuing to practise while this process is undertaken. The provisions of the Health Practitioner Regulation National Law Act 2009 empower the Board to undertake a different process in relation to ‘immediate action’ than that available under the Health Practitioners (Professional Standards) Act 1999. Under this latter Act the Board was, on forming a reasonable belief that a practitioner posed a serious potential risk to the wellbeing of vulnerable persons¹⁵⁷, able to take actual “immediate action” to suspend, or impose conditions on the practitioner’s registration if it was “necessary to protect the vulnerable persons.”¹⁵⁸ The written notice of the decision of the Board was given to the practitioner immediately after the decision to suspend or impose conditions¹⁵⁹ and not before.

Immediate action 2010

‘Immediate action’ was taken in response to six (6) notifications received in 2010¹⁶⁰. Examples of the notifications resulting in an ‘immediate action’ included allegations of the practitioner exchanging prescriptions for sex¹⁶¹, prescribing Schedule 8 drugs without the requisite authority or beyond the terms of their endorsement¹⁶³ and perforating the patient’s uterus during a

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¹⁵⁷ Health Practitioners (Professional Standards) Act 1999: Section 59(1)(a).
¹⁵⁸ Health Practitioners (Professional Standards) Act 1999: Section 59 (1)(b).
¹⁵⁹ Health Practitioners (Professional Standards) Act: Section 59(4).
¹⁶⁰ Complaint/Notification CN173, Complaint/Notification CN172, Complaint/Notification CN409, Complaint/Notification CN410, Complaint/Notification CN522, Complaint/Notification CN484.
¹⁶¹ Complaint/Notification CN173, Complaint/Notification CN172
¹⁶² Complaint/Notification CN409
¹⁶³ Complaint/Notification CN522
hysterectomy\footnote{Complaint/Notification CN484}. It is noted in relation to the latter file the practitioner had an additional outstanding matter before the Board.

\textit{Immediate action 2011}

‘Immediate action’ was taken in relation to ten (10) notifications received in 2011\footnote{Complaint/Notification CN127, Complaint/Notification CN101, Complaint/Notification CN411, Complaint/Notification CN312, Complaint/Notification CN198, Complaint/Notification CN506, Complaint/Notification CN69, Complaint/Notification CN340, Complaint/Notification CN155.}. Examples of the notifications resulting in an ‘immediate action’ included allegations that the practitioner had engaged in a sexual relationship with a patient\footnote{Complaint/Notification CN127}, had poor surgical outcomes in relation to a number of patients and consequential changes to the practitioner’s clinical privileges\footnote{Complaint/Notification CN102}, boundary violations\footnote{Complaint/Notification CN312}, inappropriate prescribing\footnote{Complaint/Notification CN340}, intoxicated while treating patients\footnote{Complaint/Notification CN506}, adverse surgical outcomes and suspension of hospital accreditation\footnote{Complaint/Notification CN69} and breaching conditions\footnote{Complaint/Notification CN340, Complaint/Notification CN439, Complaint/Notification CN261}.

\textit{Immediate action 2012}

Immediate action was taken twice in 2012\footnote{Complaint/Notification CN439, Complaint/Notification CN261} once in relation to a notification alleging inappropriate prescribing practices\footnote{Complaint/Notification CN439} and another notification alleging the practitioner struck a restrained patient with his fist\footnote{Complaint/Notification CN261}.

\textbf{5.4.2 Source of the notification}

The notifications referred to AHPRA by public/private health care institutions or the Office of the State Coroner were processed in the same manner and sequence as notifications made by the public. The panel was concerned that the process did not provide the Board with the ability to expedite these notifications in a timely manner commensurate with the level of scrutiny and investigation that had been undertaken prior to the notification being received by AHPRA. In addition the Board decisions did not, in a number of files, reflect the significance attributed to the allegation/evidence by the referring entity or institution. The following provides some examples:

- In a number of files Queensland Health, or private sector health facilities, had undertaken internal or external investigations into the practitioner’s conduct prior to making a complaint or notification. Although the Board did not replicate the investigations, and the information and recommendations from the prior investigations were available, the time taken to commence or complete the disciplinary process was inexplicably
lengthy\textsuperscript{176}. As a separate issue it is of note that the time continued to run when the Board’s disciplinary processes was being held in ‘abeyance’ awaiting the outcome of investigations being conducted by Queensland Health (or internal entities)\textsuperscript{177} or further information, relevant to the progression of the matter, was sought\textsuperscript{178}.

- Notifications from the Office of the State Coroner\textsuperscript{179, 180, 181, 182} were dealt with over time periods ranging from 60\textsuperscript{183} to 831\textsuperscript{184} days. These files were of concern to the panel in relation to both the length of time from receipt of notification to final decision by the Board, and the decisions of the Board which seemed inadequate given the findings and recommendation by the Coroner were significant enough to refer the practitioner to AHPRA. The following are two examples:

(i) In a notification which took 60 days from receipt of notification to the final decision by the Board, the Coroner had found the death of an elderly patient was caused by pulmonary thromboembolism, deep vein thrombosis, fractured neck of femur, pneumonia, chronic obstructive airways disease and hypertension\textsuperscript{185}. The Coroner found, based on evidence including the practitioner’s submission, that the practitioner “considered [the patient] had not sustained a fracture…did not order any X-ray or other review... [ordered] pain relief … [and] It appears [the practitioner] only examined [the patient’s] knee”\textsuperscript{186}. The failure of the practitioner to adequately examine and diagnose was inconsistent with two (2) other practitioners who were able to offer preliminary diagnosis without further testing. The Notification Assessment Officer’s recommendations included “1. Issue a notice [to the practitioner] to show cause…as to why conditions should not be placed on his registration in relation to attending further training and/or education in geriatric medicine. OR 2. Request further information from [the practitioner] and resolve to hold the matter in abeyance pending receipt from [the practitioner] of information in relation to his CPD activities. OR 3. Place the matter into investigation…”\textsuperscript{187}.

\textsuperscript{176} Complaint/Notification CN314 Notification December 2009- Assessment meeting October 2010, total time to decision 906 days. Complaint/Notification CN522 Notification December 2010 – Assessment meeting June 2011, total time to decision 211 days.

\textsuperscript{177} Complaint/Notification CN211: Held in abeyance awaiting information from the Drugs and Poisons Policy and Regulation Unit, Complaint/Notification CN117 and Complaint/Notification CN483 awaiting outcomes of Queensland Health Investigations

\textsuperscript{178} Complaint/Notification CN195

\textsuperscript{179} Complaint/Notification CN146

\textsuperscript{180} Complaint/Notification CN339

\textsuperscript{181} Complaint/Notification CN292

\textsuperscript{182} Complaint/Notification CN64

\textsuperscript{183} Complaint/Notification CN146

\textsuperscript{184} Complaint/Notification CN64

\textsuperscript{185} Complaint/Notification CN146: Form 20A Version 2 p.5, dated 2 August 2010

\textsuperscript{186} Complaint/Notification CN146: Form 20A Version 2 p.4, dated 2 August 2010

\textsuperscript{187} Complaint/Notification CN146 Notification and Assessment Committee: Assessment recommendation dated 13.10.2010.
However, the decision of the NAC noted by the Board was NFA “because the notification was lacking in substance”\(^{188}\);

(ii) A voluntary notification from the Coroner, which took 366 days before a final decision by the Board,\(^{189}\) was based on the Coroner’s findings that the practitioner had not provided an adequate standard of care to the deceased patient, had made fraudulent statements and altered documents (medical records) submitted to the Court\(^{190}\). The practitioner had a notification history including nine (9) prior complaints to the Board and 18 prior complaints against the practitioner to the HCQQ\(^{191}\). It was approximately 12 months after the Coroner’s notification that the PPSC recommended “immediate action” be taken by the Board as “there was sufficient evidence to form a reasonable belief that because of the registered practitioner’s performance, the practitioner poses a serious risk to persons and it is necessary to take immediate action to protect public health and safety”\(^{192}\). The Board imposed conditions on the practitioner after seeking a submission and then referred matter to QCAT.

5.4.3 Health Quality and Complaints Commission (HQCC)

The cross jurisdictional referral and consultation obligations imposed respectively under the Health Practitioners (Professional Standards) Act 1999, Health Quality and Complaints Commission Act 2006 and the provisions of the Health Practitioner Regulation National Law Act 2009, in relation to complaints/notifications, resulted in substantial delays and inconsistencies in the processing and outcomes of a significant number of the files. In a number of files the processing of complaints/notifications received by either the HQCC or AHPRA were held in abeyance or effectively stalled (with no activity) as they traversed the reciprocal notification and information sharing requirements imposed under the legislation. It was evident that the compliance with processes prescribed by the legislation for the receipt, assessment and investigation of notifications by AHPRA and the HQCC resulted in a blurring of the roles (of the entities) and was an important factor in both the delays in the time taken to address a complaint/notification and the appropriateness of the outcomes.

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\(^{188}\) Complaint/Notification CN146Notification Assessment Committee: Decisions and actions arising dated 13 October

\(^{189}\) Complaint/Notification CN339 It is noted that the Notification by the Coroner was dealt with simultaneously with a prior complaint

\(^{190}\) Complaint/Notification CN339 Investigation Report dated 27.9.2011 at p.6 and p10: “…[the practitioner] had misled the court by fraudulently altering the computerised medical records of [the patient’s] consultation to make it appear he had recommended [the patient] be admitted to hospital”

\(^{191}\) Complaint/Notification CN339 Investigation Report dated 27.9.2011 at p.9

\(^{192}\) Complaint/Notification CN339 Performance and Professional Standards Committee, Agenda Papers 27.9.2011
For example, the Board was obliged to refer a complaint to the HQCC unless the complaint came within section 51(2)\textsuperscript{193} of the \textit{Health Practitioners (Professional Standards) Act 1999}. When the Board referred a complaint under section 51, the board was not to “take any further action on the complaint unless the commission [referred] the complaint back to the Board under the HQCC Act.”\textsuperscript{194}

Similarly, the \textit{Health Practitioner Regulation National Law Act 2009} s. 150 states:

1. “If the subject matter of a notification would also provide a ground for a complaint to a health complaints entity…the National Board that received the notification must, as soon as practicable after its receipt –
   - (a) notify the health complaints entity…
   - (b) give to the health complaints entity –
     - (i) a copy of the notification…
     - (ii) any other information…

2. If a health complaints entity receives a complaint about a health practitioner, the health complaints entity must, as soon as practicable after its receipt –
   - (c) notify the health complaints entity…
   - (d) give to the health complaints entity –
     - (iii) a copy of the notification…
     - (iv) any other information…

3. The National Board and the health complaints entity must attempt to reach agreement about how the notification or complaint is to be dealt with…

4. If…not able to reach agreement on how…complaint, is to be dealt with, the most serious action proposed by either must be taken

5.

6. If a notification or part of a notification, received by a National Board is referred to a health complaints entity, the Board may decide to take no further action in relation to…

\textsuperscript{193} Section 51(2)(a) following consultation between the board and the commission, the board and the commission agree it is in the public interest for the board to do 1 of the following: (i) keep the investigation under the investigation part; (ii) keep the complaint and start disciplinary proceedings under the disciplinary proceedings part; (iii) keep the complaint and deal with it under the impairment part; (iv) keep the complaint and deal with it under the inspection part or the health practitioner registration Act under which the board is established…; (v) refer the complaint to another entity that has the function and power under an Act of the State, the Commonwealth or another State to deal with the matter; or (a) the board rejects the complaint under section 54 (IAA); or (b) the board keeps the complaint under a standing arrangement entered into between the board and the commission…; (c) the board, under the immediate suspension part, suspends or imposes conditions on, the practitioner’s registration; or (d) the complaint is about a matter that happened before 1 July 1991 and the complainant was aware of the matter before 1 July 1991.

\textsuperscript{194} \textit{Health Practitioners (Professional Standards) Act 1999} s.52.
the notification or the part of the notification until the entity gives the Board written notice that the entity has finished dealing with it”

The implications for complaints/notifications being dealt with by two (2) separate entities, as prescribed under the current legislation, are evident in the following files which represent a small number of the total number of files in which significant delays (and in the panel’s view the consumption of significant resources) were attributable to reciprocal referrals, consultation requirements and the duplication of processes such as assessments, clinical opinions, expert opinions and investigations.

- A complaint made to the HQCC in March 2011 alleged a failure by the practitioner to assess and diagnose a patient which had resulted in a poor medical outcome. The complaint was initially assessed by the HQCC with the clinical advice obtained being critical of the practitioner’s treatment. The HQCC therefore consulted with the Board (as required under s 150(3) of the Health Practitioner Regulation National Law Act 2009) recommending the complaint be referred to the Board/AHPRA. In October 2011 the NAC resolved to disagree with the HQCC and recommended the complaint be retained by the HQCC with the Board taking NFA. This decision was returned to the HQCC in November 2011 and, in January 2012, the HQCC “responded and resolved to disagree with the committee’s [NAC] reasoning and …requested further reasoning be provided”. The HQCC’s response based on “consultation with a suitably qualified medical practitioner” held to the view “that the matter is suitable for referral to the Board for appropriate action…[B]efore referring pursuant to s 150(4), we would invite any additional reasoning or further comment the Board may wish to make”. In February 2012 the NAC, on behalf of the Board supplied further reasoning while maintaining the original decision to refuse the referral and take NFA.

- A notification received by AHPRA in February 2011 held in abeyance waiting information from the HQCC until August 2011. The decision of the NAC to take NFA was not noted by the Board until October 2011.

- A complaint received in March 2010 held in abeyance pending the outcome of the HQCC investigation was not finalised by the Board until February 2012 (695 days after the complaint was received) to take NFA on the basis that the “notification has been dealt with, adequately by another entity, namely the Health Quality and Complaints Commission”. 

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195 Complaint/Notification CN258 Health Quality and Complaints Commission s 150(3) Consultation with AHPRA dated 2.10.2011
196 Complaint/Notification CN258 Notification Assessment Committee Agenda paper dated 8 February 2012
197 Complaint/Notification CN258 Notification Assessment Committee Agenda paper dated 8 February 2012
198 Complaint/Notification CN164
199 Complaint/Notification CN293
• A notification received by AHPRA from the HQCC in February 2011 did not progress until the independent clinical advice obtained by the HQCC was forwarded in June 2011 and an assessment meeting of the NAC conducted in February 2012. The matter was not finalised until June 2012 (483 days after the notification).

The panel was also concerned by the number of complaints/notifications the HQCC recommended for referral to be dealt with by the Board which were either rejected by the Board or, if accepted by the Board, resulted in an NFA decision. The following describe some (but not all examples) of the files which the Board rejected the recommendation of the HQCC that the Board deal with the complaint/notification and thereby recorded as NFA:

• An allegation that a practitioner breached the patient’s confidentiality by providing a third party with the patient’s medical certificate and referral to a psychiatrist. The Board disagreed with the recommendation by the HQCC that the Board deal with the notification;
• An allegation that the practitioner did not appropriately assess a patient or order an x-ray which resulted in a failure by the practitioner to diagnose a fractured leg. An additional allegation related to inappropriate treatment based on the practitioner’s misdiagnosis. While AHPRA recommended Show Cause Caution the decision of the NAC noted by the Board was for the HQCC to retain the complaint and take NFA.

The following are some (but not all) examples of files reviewed by the panel in which the Board accepted the referral of the complaint/notification from the HQCC (the HQCC having determined the complaint warranted a referral) but the Board then determined to take NFA on the ground that the complaint “does not provide a ground for disciplinary action”:

• Allegations the practitioner failed to provide adequate warming about bio-identical hormone therapy which resulted in the patient suffering breast cancer;
• An allegation that the practitioner misdiagnosed a seborrheic keratosis as a pre-cancerous lesion and recommended surgery requiring a general anaesthetic when it was appropriately removed by another practitioner in the surgery with local anaesthetic (on referral AHPRA had recommended investigation);

200 Complaint/Notification CN251 Queensland Board of the Medical Board of Australia, Show Cause Agenda Paper dated 12 June 2012
201 Complaint/Notification CN251 Queensland Board of the Medical Board of Australia, Record of Decisions and Actions Arising dated 12 June 2012
202 Complaint/Notification CN567
203 Complaint/Notification CN384
204 Complaint/Notification CN59
205 Complaint/Notification CN80: Notification Assessment Committee, Agenda Paper dated 11 April 2011
• An allegation that the practitioner misdiagnosed a patient as having Bell’s palsy when the patient had suffered a stroke\(^{206}\) (on referral, the Office of the Medical Board – pre transition recommended Discipline by Hearing).

**Process issues:**

The following process issues were identified in the files and give cause for concern as to the actual benefits of two (2) entities having jurisdiction to accept and manage complaints about health professionals:

• The HQCC made a notification to AHPRA expressing an intention to deal with the complaint following an assessment. The HQCC confirmed that it would notify the Board under section 52 and consult with the Board under section 57 of the *Health Quality and Complaints Commission Act* 2006 however, after two (2) months no response or consultation had occurred and the file was closed\(^{207}\);

• Two months after AHPRA received verbal notification from the HQCC in relation to a complaint it was followed up with no response. After no consultation was received from the HQCC the file was closed\(^{208}\). Similarly a notification was received from HQCC “verbally only”. There was no response to AHPRA’s attempt to follow up the matter and after no consultation was received the file was closed\(^{209}\);

• The HQCC forwarded a notification to AHPRA advising that the commission was unable to take action as the complaint was out of time but it was agreed to “informally” provide the material to AHPRA for “review and any action deemed appropriate”\(^{210}\).

**5.4.4 Involvement of other entities**

In a small number of files the delay in processing a notification or investigation was due to the involvement of entities such as the Drugs of Dependence Unit (DDU)\(^{211}\), Medicare\(^{212}\) and/or the Federal or Queensland Police Services\(^{213}\). There were also considerable delays in the assessment or investigation of complaints/notifications while expert and independent medical opinions were sought.

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\(^{206}\) Complaint/Notification CN480

\(^{207}\) Complaint/Notification CN392

\(^{208}\) Complaint/Notification CN181

\(^{209}\) Complaint/Notification CN275

\(^{210}\) Complaint/Notification CN92 Notification Assessment Committee, Agenda Paper dated 2 November 2011

\(^{211}\) Complaint/Notification CN409, Complaint/Notification CN410, Complaint/Notification CN411

\(^{212}\) Complaint/Notification CN294, Complaint/Notification CN87

\(^{213}\) Complaint/Notification CN174: delay awaiting information from QPS September 2010 to April 2011
6 APPROPRIATENESS

The ‘appropriateness’ of QBMBAs responses to complaints and notifications was considered by the panel with reference to the legislative obligation of protecting the public and specifically, for complaints dealt with prior to July 2010 and transitioned under the National Scheme, compliance with section 6 of the Health Practitioners (Professional Standards) Act 2009. To facilitate the process of review each file was categorised according to the nature of the complaint/notification. The five categories and the number of files in each category were:

- Misdiagnosis and/or failure to diagnose (58)
- Poor medical practices and surgical outcomes (142)
- Prescribing irregularities (47)
- Boundary violations (29)
- Official misconduct (87)

The panel conducted an examination and review of the files and considered the nature of the complaints and the appropriateness of the responses and outcomes to those complaints. The panel considered the appropriateness of decisions in terms of predictability and consistency of the final decisions across the files based on complaints/notifications that were similar in nature. The panel then considered the ‘appropriateness’ of particular outcomes in light of the overarching obligation of the MBQ/QBMBAs to protect the public and ensure the practitioners are safe and competent to practise.

6.1 Misdiagnosis and/or a failure to diagnose

Complaints and notifications based on a practitioner’s failure to adequately assess, examine and diagnose were predominantly made by the patients or their relatives. The proportion of files in this category was 16% of the targeted files. The files examined below demonstrate that the Board’s final decisions were not consistent and/or predictable across complaints/notifications of a similar nature. It was also noted that the majority of the 58 files (both legacy and non-legacy), examined on the basis of complaints/notifications alleging that the practitioners had misdiagnosed or failed to diagnose, resulted in a Board decision of NFA. Refer Figure 6-1.

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214 That complaints/notifications were progressed and determined in a manner consistent with the maintenance of professional standards and the public’s confidence in the profession
215 Board decision NFA: 40. Five (5) of the files resulted in a Caution (Complaint/Notification CN359, Complaint/Notification CN288, Complaint/Notification CN374, Complaint/Notification CN382, Complaint/Notification CN458), six (6) Discipline by Hearing (Complaint/Notification CN126, Complaint/Notification CN549, Complaint/Notification CN550, Complaint/Notification CN222, Complaint/Notification CN78, Complaint/Notification CN356), three (3) as Discipline by Correspondence
Figure 6-1 Outcomes for Misdiagnosis

The decision to take NFA was the outcome even when the complaints/notifications were based, as acknowledged by the Board in the Reasons for their decisions, on clinically and professionally significant allegations.

In a number of files the practitioners misdiagnosed, or missed the correct diagnosis of, a patient’s illness, injury, disease or disorder. The following are some (but not all) of the files which illustrate decisions by the Board which were not only inconsistent across allegations of a similar nature but also failed to make provision for the assessment, or confirmation, of a practitioner’s competency to practise into the future:

- Notification that the practitioner failed to review or action a patient’s abnormal histopathology result which was positive for adenocarcinoma. The allegation also included that the practitioner had failed to inform the patient of the abnormal result and later attempted to conceal the histopathology result\(^\text{216}\). AHPRA recommended Discipline by Panel however, the NAC sought an investigation (which took 14 months to conclude). The investigation found that there was sufficient evidence “on which the

\(^{216}\) Complaint/Notification CN458

14% Caution
7% Discipline by Correspondence
10% Discipline by Hearing
2% Undertaking
65% NFA
2% QCAT

Misdiagnosis Outcomes
Board could form a reasonable belief that [the practitioner’s] professional conduct is, or may be, of a lesser standard than that which might be reasonably be expected of the practitioner by the public or his professional peers.”\(^\text{217}\). The decision of the Board was to Caution the practitioner.

- Allegation in relation to another practitioner in the same clinical unit as described in (i) failed to review, or action, a patient’s abnormal histopathology results which were positive for adenocarcinoma, failed to inform the patient of the abnormal results, failed to coordinate appropriate follow up care which resulted in a three (3) month delay in the patient receiving appropriate treatment\(^\text{218}\). AHPRA recommended NFA however the NAC sought an investigation which was completed after 14 months. The investigation concluded that “there is sufficient evidence on which the Board can form a reasonable belief that the practitioner’s performance amounts to unsatisfactory professional conduct or professional misconduct”\(^\text{219}\). The decision of the Board was NFA.

- Notification alleged the practitioner had failed to diagnose (HELLP), a variation of pre-eclampsia, which contributed to the stillbirth of a baby and placed the mother’s life at risk\(^\text{220}\). The decision of AHPRA and NAC, to investigate, included reference to a prior and open notification alleging “inappropriate treatment” and “not acting appropriately when a woman suffered cord prolapse resulting in the death of her baby”\(^\text{221}\). The Board, after consideration of the Investigation Report, decided to Caution the practitioner\(^\text{222}\) while also noting; “That, with a suspicion of pre-eclampsia an appointment to be seen within two days was not made; the appointment was made for a week later. A prompt follow-up of the investigation of the blood tests was not undertaken. There is sufficient evidence that [the practitioner’s] knowledge, skill or judgement exercised in the treatment of [the patient] was of a lesser standard that that reasonably expected by the public or her peers”.

In a number of files the practitioners failed to correctly diagnose patients following CT scans, ultrasounds, mammograms and other clinical testing. It is evident from the files considered that the outcomes are inconsistent with the nature and significance of the diagnostic errors and did not address the practitioner’s competency to continue in their clinical practice. The following are some (but not all) of the files which illustrate this proposition:

- Notification\(^\text{223}\) involving a practitioner making an incorrect conclusive finding on a pelvic ultrasound conducted seven and a half years (7½) previously. AHPRA requested

\(^{217}\) Complaint/Notification CN458 Performance and Professional Standards Committee, Agenda Papers dated 12 June 2012
\(^{218}\) Complaint/Notification CN221
\(^{219}\) Complaint/Notification CN221 Investigation Report dated 16.5.2012
\(^{220}\) Complaint/Notification CN33
\(^{221}\) Complaint/Notification CN33 Notifications Assessment Committee Agenda Papers dated 15 June 2011
\(^{222}\) Complaint/Notification CN33 QBMBA Decisions and Actions arising date 13 March 2012
\(^{223}\) Complaint/Notification CN118
Caution, the NAC sought a Show Cause Caution to which the practitioner responded with a submission. It was the decision of the Board to take NFA.

- Notification alleging the practitioner failed to report on a large mass evident in a CT scan of the patient’s abdomen. The mass was later confirmed on CT scan as Appendiceal Mucinous Neoplasm. The failure by the practitioner resulted in a delay in the diagnosis and treatment. It is noted that the practitioner admitted his failure to report the presence of the mass and stated the failure could only be explained “as an aberration and human failure.” Both AHPRA and NAC requested Show Cause Caution to which the practitioner responded with a submission. The submission contained admissions including “…it is clear that I did not provide a comprehensive report, however this is not my usual practice”.

- Despite this admission the Board’s decision was NFA on the grounds that the practitioner “admitted his error and apologises for the oversight…acknowledges the claim for compensation…and this error has made him “more aware of the need to double check his findings and I believe that it is something that will not be repeated going forward”.

- Notification alleging the practitioner incorrectly advised a patient in relation to the results of a breast ultrasound and mammogram. The practitioner’s failure to advise correctly, resulted in a delay in the diagnosis of breast cancer and the consequential spread of the cancer to the patient’s spine and lymph nodes. While AHPRA requested an Investigation the NAC sought Show Cause Caution which was approved by the Board and for which the practitioner provided a submission. The Board’s decision, to Caution the practitioner, appears profoundly inadequate when considered against the Board’s own Reasons for decision that:

  “…
  b. [the practitioner’s] clinical notes are inadequate and fall below the standard of acceptable record keeping.
  c. [the practitioner] failed to understand the significance of the ultrasound performed … in light of the patient’s previous episode of breast disease.
  d. [the practitioner] did not take action to investigate the presence of lymph nodes on the ultrasound report.

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224 Complaint/Notification CN135
225 Complaint/Notification CN135 Health Quality and Complaints Commission s.150(3) Consultation with AHPRA dated 5.4.2011
226 Complaint/Notification CN135 Submission dated 25.2.2011
227 Complaint/Notification CN135 QBMBA Record of decisions and actions arising, dated 13 September 2011
228 Complaint/Notification CN374 Health Quality and Complaints Commission Notification to AHPRA of new complaint received dated 22.2.2011
229 Complaint/Notification CN374 QBMBA Record of decisions and actions arising, dated 14.2.2012
e. [the practitioner] does not appear to have followed any logical clinical process in the management of the patient."

- Allegations in relation to a patient who had been prescribed antibiotics, and referred for a urinary tract ultrasound, for severe urinary tract pain. The practitioner informed the patient, after reviewing the ultrasound report, that the patient had large gallstones and required surgery to remove his gallbladder. The patient remained on a waiting list, and in severe pain, for three (3) months during which the patient was reviewed by the practitioner “a couple of times and prescribed antibiotics”. The notification was based on allegations of unsatisfactory treatment and management, and a failure to identify an error in a renal tract ultrasound report, which led to delay in treatment. Both AHPRA and NAC recommended Show Cause Caution to which the practitioner responded with a submission. The Board’s decision to Caution the practitioner appears not to reflect the seriousness of the notification which was evident in the Board’s own Reasons:

  a. [the practitioner’s] treatment and management of [the patient] , who was suffering pain …was unsatisfactory.
  
b. [The practitioner’s] failure to identify an error in the renal ultrasound report…is unsatisfactory.
  
c. The clinical situation did not indicate gallstones…and [the practitioner] should have identified this error in the ultrasound report.
  
d. Misdiagnosis was reasonably avoidable….
  
e. The delay in diagnosis may have contributed to ongoing morbidity.

  f. The Board has formed a reasonable belief that the way [the practitioner] practised the profession is unsatisfactory.

- Notification alleging the practitioner failed to diagnose two (2) cerebral aneurysms on a CT scan of a patient who presented complaining of acute headache, vomiting and being unable to sit upright. Although the radiologist reported the CT scan showed a subarachnoid haemorrhage the practitioner, after reviewing the CT scan, took no action advising the patient she had not suffered a stroke, prescribing an injection for the pain and discharging the patient home. The patient continued to suffer “cluster headaches” and, three (3) years later, sought a second opinion. The patient was then diagnosed with the cerebral aneurysms (which were visible on the previous CT scan)

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231 Complaint/Notification CN374 QB MBA Record of decisions and actions arising, dated 12.6.2012
232 Complaint/Notification CN251 Health Quality and Complaints Commission s150(3) Consultation with AHPRA dated 19.10.10
233 Complaint/Notification CN251 Queensland Board of the Medical Board of Australia Record of decision and actions arising dated 12 June 2012
234 Complaint/Notification CN359 Notification Assessment Committee, Decisions and actions arising dated 15 December 2010
and underwent surgery\textsuperscript{235}. AHPRA and NAC recommended a Show Cause Caution which was adopted by the Board\textsuperscript{236} and resulted in the submission by the practitioner. The practitioner was Cautioned with “Disciplinary action not recorded on the public register”\textsuperscript{237}. The Reasons provided by the Board included; “There was sufficient evidence to form a reasonable belief that a disciplinary matter exists…in his submission [the practitioner] admits that an error occurred when he failed to notice either the contents or significance of the report and his failure might have had very serious consequences for the patient”.

Notifications that the practitioner had failed to conduct adequate, or appropriate, physical examinations were predominantly uncomplicated allegations focused on basic clinical skills. The decisions of the Board in a number of these files were difficult to reconcile with the overriding obligations to make determinations which maintained a standard of practice within the profession and ensured practitioners were competent and safe to practise:

- Notification alleging the practitioner (who had been treating the patient for the previous seven (7) years) failed to adequately assess and diagnose the patient’s symptoms, failed to instruct the patient to go to hospital if the pain increased, denied knowledge of the patient when contacted by Police after the patient’s death and would not sign the patient’s death certificate because the practitioner was on holiday\textsuperscript{238}. AHPRA and NAC sought a Show Cause Caution, which was accepted by the Board. The practitioner responded to this decision with a submission following which the Board decided to approve the recommendation of the NAC not to Caution the practitioner but rather made a final decision of NFA.

- Notification alleging the practitioner failed to conduct an adequate assessment when the patient presented with facial tingling, loss of feeling and strength on his left side and light headedness. The practitioner ordered blood tests and a CT scan for the following day however, prior to the test, the patient was admitted to the hospital and subsequently diagnosed with having suffered two (2) transient ischaemic attacks\textsuperscript{239}. While AHPRA recommended an Investigation the NAC, noting the “substandard treatment” provided to the patient, sought a Show Cause Caution. A submission from the practitioner was sought following the Boards adoption of the NAC decision. The practitioner failed to make a submission in response to the Show Cause notice and the Board decided to Caution the practitioner for “unsatisfactory professional conduct”\textsuperscript{240}. The decision to Caution, with no further assessment or supervision of the practitioner appears inconsistent with the Reasons for the decision by the Board:

\textsuperscript{235} Health Quality and Complaints Commission, Internal Report, dated 17.8.2010
\textsuperscript{236} Complaint/Notification CN359 QBMBA Record of Decisions and Actions arising, dated 12.5.2011
\textsuperscript{237} Complaint/Notification CN359 QBMBA Record of Decisions and Actions arising, dated 23.5.2011.
\textsuperscript{238} Complaint/Notification CN51.
\textsuperscript{239} Complaint/Notification CN288.
\textsuperscript{240} Complaint/Notification CN288 QBMBA Record of Decision and Action arising dated 14 February 2012.
“a. [The practitioner’s] practice of the profession …is unsatisfactory.
b. [The practitioner] has not provided any additional information.…
c. The clinical assessment and treatment was substandard and there was no supporting documentation.
d. The note indicates a poor evaluation and no appreciation of the seriousness of the situation.
e. [the practitioner’s] record keeping was unsatisfactory”

- Notification that the practitioner failed to act on symptoms indicating a paediatric patient was suffering from hypercalcaemia. The patient was subsequently admitted to hospital for treatment of hypercalcaemia which included investigation, treatment and surgery for the removal of a parathyroid adenoma. At the time of the notification the practitioner was holding a limited registration. AHPRA recommended Show Cause Caution however the NAC recommended NFA which was noted by the Board. The HQCC disagreed with the decision and requested further reasoning which was rejected by the NAC.

6.2 Poor medical practices and surgical outcomes

There was a total of 142 complaints/notifications received in relation to poor medical practices and surgical outcomes. This category of complaints/notifications represented the largest group, comprising 39% of targeted files. The outcomes were varied and included 87 NFA’s, 20 Discipline by Hearing, 14 referrals to QCAT, five (5) Undertakings and two (2) Panel referrals. Refer Figure 6-2.

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241 Complaint/Notification CN288 QBMBA Record of Decision and Action arising dated 14 February 2012
242 Complaint/Notification CN469
243 Complaint/Notification CN469, Notification Assessment Committee Agenda papers dated 29.6.2011
6.2.1 Medical Practices

The following legacy files provide some (but not all) examples of decisions by the Board which the panel considered were not consistent with the obligations imposed under the legislation to protect the public, uphold the standards of practice and maintain the public’s confidence in the medical profession:

- In a complaint alleging that the practitioner failed to respond to the patient or nursing staff’s requests to attend the patient (as the patient’s condition deteriorated necessitating two (2) admissions to the ICU where artificial ventilation was required), transfer the patient to another hospital or facilitate a second medical opinion, the Board decision was to approve the NFA recommendation of the PPSC. The findings of the Preliminary Investigation Report that there was “sufficient evidence on which the Board could have formed a reasonable belief that a disciplinary matter exists” was confirmed by the PPSC documents which state “…the Board could have dealt with the matter by referring the matter for disciplinary

244 Health Practitioners (Professional Standards) Act 1999 s.6
245 Complaint/Notification CN225 Queensland Board of the Medical Board of Australia, Record of Decisions and Actions arising dated 24.1.2012
proceedings…” The decision to take NFA, and close the complaint, was based on the practitioner having voluntarily relinquished their registration and applying for a non-practising registration status. It was a concern to the panel that the course of action taken by the practitioner resulted in avoiding any disciplinary repercussions while still maintaining their title (if not their practice). This is despite section 9 of the Health Practitioners (Professional Standards) Act 1999 which expressly provides for the application of the Act, and thereby the jurisdiction of the Board, in relation to disciplinary action when a person is no longer registered;

- The Board also decided to take NFA following allegations that the practitioner had failed to provide adequate levels of asthma treatment and medication to a child. The NAC recommended an investigation, obtaining third party information and an expert clinical opinion. The Preliminary Investigation Report was adopted and the PPSC recommended to the Board that a Disciplinary Committee be established to commence disciplinary proceeding by way of a hearing. The reason for the PPSC decision was based on the findings and recommendations in the Investigation Report that included: the practitioner’s treatment did not fall within accepted best medical practice guidelines and the practitioner had not provided sufficient evidence to substantiate his assessment of the patient “was appropriate”, or that he had implemented a “suitable management plan” or “appropriately and suitably referred [the patient] to a paediatric respiratory physician”. Despite the findings and recommendations of the Investigation Report and the PPSC the Board decided “[t]here is insufficient evidence for the Board to form a reasonable belief that a disciplinary matter exists in relation to the conduct of [the practitioner]…no further action be taken about the matter” as the Board “considered the evidence does not reach the threshold for disciplinary action”;

- A complaint forwarded to the Board by an Executive Director of Medical Services alleging the practitioner’s response to a patient who had sustained significant cervical

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250 Complaint/Notification CN232 Performance and Professional Standards Committee, Record of Decisions and Actions Arising dated 27.9.2011
251 Complaint/Notification CN232 Queensland Board of the Medical Board of Australia, Record of Decisions and Actions Arising dated 22.11.2011
spinal damage demonstrated a “lack of appropriate assessment and action”. The NAC decided to place the matter into investigation and the PPSC to appoint an independent expert to provide an opinion. At completion of the Investigation the PPSC recommended the Board “establish a disciplinary committee to commence disciplinary proceedings by way of hearing…[and] consider imposing conditions on the practitioner’s registration in relation to supervision”. The issues included a “scathing report on [the practitioner’s] competence” written by the medical expert and the fact that the practitioner had been dismissed from the specialty training program. The decision recommended by the PPSC and noted by the Board was to conduct disciplinary proceeding in the form of a hearing, “to take Immediate Action” and accept an undertaking requiring supervision. This decision was made, and noted by the Board, 20 months after the complaint was received.

The decisions of the Board, in relation to the non-legacy files based on notifications alleging poor medical practices, were considered by the panel. The following are some (but not all) of the Board’s decisions which the panel considered illustrated outcomes which went towards appropriately directed to protecting the public:

- In a notification made by an employing health care institution it was alleged the practitioner had firstly failed to follow the institution’s head injury protocol when assessing a patient who subsequently died from an inoperable subdural and intracranial haemorrhage and secondly, supervised a junior practitioner to carry out a procedure which resulted in the patient’s condition deteriorating and requiring transfer and surgical intervention at another health care facility. The employer had, based on the practitioner’s conduct, reduced the practitioner’s scope of practice however the practitioner failed to notify the Board of this as required by s 130 Health Practitioner Regulation National Law Act. The NAC’s decision to take NFA, as the practitioner’s

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252 Complaint/Notification CN279 Notification and Assessment Committee, Decisions and Actions Arising dated 23.2.2011. Although this complaint was received in December 2009 it did not come before an assessment meeting until February 2011 and was therefore assessed by the NAC rather than the CAC.


257 Complaint/Notification CN161 Notification and Assessment Committee, Agenda Paper dated 27.10.2010.
conducted was being addressed by Clinician Performance Support Services (CliPSS)\textsuperscript{258}, was noted by the Board\textsuperscript{259};

- The PPSC decided, in relation to a notification alleging the partitioner’s clinical management of a patient may have resulted in the patient suffering cardiac complications, that “there is sufficient evidence for the Medical Board of Australia to form a reasonable belief that a disciplinary matter exists in relation to [the practitioner] on the following grounds: Unsatisfactory professional conduct”\textsuperscript{260}. The PPSC recommendation to establish a disciplinary committee to conduct disciplinary proceedings by way of hearing,\textsuperscript{261} was adopted by the Board\textsuperscript{262};

- In a notification based on the practitioner’s treatment of a patient with a therapy that had not been approved for use in Australia, and was considered “unconventional Medical Practice”, the Board resolved to order the practitioner “undergo a performance assessment…as the Board reasonably believes that the way the practitioner practises the profession is or may be unsatisfactory; and… the practitioner be cautioned”\textsuperscript{263}.

6.2.2 Surgical Outcomes

The following provide some examples of a lack of consistency in the Board decisions in relation to the legacy files:

- In a complaint alleging the failure by a practitioner, who had assumed the postoperative care of a patient, to recognise the extent of the patient’s post-operative complications, attend to the patient when requested, provide accurate and adequate information appropriately and facilitate a transfer to another hospital, the Board resolved to commence disciplinary proceedings by referring the practitioner for hearing and determination to the QCAT\textsuperscript{264}. The decision was soundly based on the outcome and recommendation of a Preliminary Investigation Report and two (2) independent expert opinions; however

\textsuperscript{258} Complaint/Notification CN161 Notification and Assessment Committee, Decisions and Actions Arising dated 27.10.2010

\textsuperscript{259} Complaint/Notification CN161 Queensland Board of the Medical Board of Australia, Decisions and Actions Arising dated 9.11.2011.


\textsuperscript{261} Complaint/Notification CN222 Performance and Professional Standards Committee Record of Decision and Actions Arising dated 6.12.2011.

\textsuperscript{262} Complaint/Notification CN222 Queensland Board of the Medical Board of Australia, Record of Decisions and Actions Arising dated 24.1.2012.

\textsuperscript{263} Complaint/Notification CN27 Queensland Board of the Medical Board of Australia, Decisions and Actions Arising dated 28.2.2012.

\textsuperscript{264} Complaint/Notification CN142 Queensland Board of the Medical Board of Australia, Decisions and Actions arising dated 10.8.2010.
• In relation to a complaint alleging the practitioner “nicked the bowel” and failed to provide adequate post-operative care resulting in the patient being transferred to another hospital with “a 2 cm hole in her stomach which had apparently become septic,” the Board, without conducting an investigation or obtaining independent expert opinion, noted the NFA decision of the NAC. The determination of the NAC was based on the finding that “this complaint does not provide a ground for disciplinary action as required by s48 of the Health Practitioners (Professional Standards) Act 1999.” It is of note that at the time this complaint about the practitioner was being dealt with by the NAC and Board there had been three (3) previous complaints received by the Board of which two (2) were referred to the HQCC and the third rejected.

In relation to the non-legacy files the decisions of the Board were more predictable and consistent according to the nature and significance of the notifications and the investigation recommendations:

• In a notification alleging inappropriate and unprofessional treatment of a patient’s non-viable pregnancy the investigator recommended NFA based on a finding that there was “insufficient evidence on which the Board can form a reasonable belief that the practitioner’s performance amounts to unsatisfactory professional conduct or professional misconduct”. The PPSC resolved to take NFA;

• Where the Board determined that there was sufficient evidence upon which a reasonable belief could be formed that the “practitioner’s practice of the profession amounted to unsatisfactory professional performance” the practitioner was referred to a Performance and Professional Standards Panel;

• The Board approved the NAC recommendation that the practitioner’s conduct constituted “professional misconduct as defined by schedule 5 of the Health Practitioner Regulation National Law Act 2009...[and] referred [the practitioner] to the Queensland Civil and Administrative Tribunal”. The decision was based upon the independent expert opinion which was critical of the practitioner’s treatment, identification of a “pattern of conduct or behaviour”, that the practitioner had breached existing conditions

265 Complaint/Notification CN365 Notification and Assessment Committee, Decisions and Actions Arising dated 9.3.2011.
266 Complaint/Notification CN365 Notification and Assessment Committee, Decisions and Actions Arising dated 9.3.2011.
269 Complaint/Notification CN8 Investigation Report dated 22.5.2012.
270 Complaint/Notification CN8 PPSC Records of Decision and Action arising dated 22.5.2012.
271 Complaint/Notification CN149-The Board approved the PPSC recommendation: Queensland Board of the Medical Board of Queensland Decisions and Actions Arising 24.1.2012.
272 Complaint/Notification CN464 Queensland Board of the Medical Board of Australia, Record of Decisions and Action arising dated 6.12.2011.
“on a number of occasions” and the practitioner’s records were “inadequate, with a lot of information missing”.

6.3 Prescribing Irregularities

Prescribing irregularities represented 13% of the targeted files. The nature of the 47 complaints/notifications (legacy and non-legacy) examined by the panel based on allegations of poor prescribing practices by practitioners varied greatly. The outcomes of these files also ranged from NFA (18 files), to referral to the QCAT (13 files). Refer Figure 6-3.

The following are two (but not all) examples of complaints/notifications in which the Board determined that the decision of NFA was the appropriate outcome. It is noted that the practitioners were effectively enabled, by the decision, to continue their practice without any assessment of their competency, monitoring, supervision or oversight of their practice. In one of the files described below the decision was based on the practitioner’s ‘word’ as to what they had done, and would do, so as not to repeat their mistake.

- The practitioner administered, by single injection, four (4) months supply, eight (8) doses of a medication to a patient which resulted in on-going side effects. The practitioner

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advised that the serum had been administered by him even though it was not clearly marked with the patient’s name or a description of the contents or any form of instructions. The practitioner “advised that he did not have any knowledge regarding this practice before he obtained patient consent and administered the serum”. AHPRA and NAC recommended a Show Cause Caution which was adopted by the Board and to which the practitioner responded with a submission. The final decision of the Board was NFA which was based on the following reasons; the practitioner had “provided a satisfactory response…taken steps to ensure that the situation does not reoccur…advised he was planning to attend relevant training about “minimising the risk of medical errors”…has attended a workshop on the topic of “Adverse Outcomes”…[and] there is little evidence that the patient suffered long term harm.”

- The notification was made by the estranged husband of the patient for whom the practitioner was prescribing dexamphetamine. The allegations included the practitioner was prescribing the drug when he “should have known” the patient had addiction problems, ignored the signs of addiction, prescribed “roughly four times the maximum recommended therapeutic dose and prescribed large amounts with repeat doses. That the practitioner commenced the patient on large doses of atomoxetine, supplied scripts for 200 tablets of clonazepam “simply to supply her with a massive quantity of benzodiazepine”. Both AHPRA and NAC recommended an Investigation which was completed in seven (7) months. The investor found the behaviour constituted unprofessional conduct and recommended the practitioner undergo further education and training and a period of supervised practice. AHPRA, based on the Investigation Report and recommendations, sought the imposition of Conditions (in line with the recommendation) however the PPSC recommended NFA which was adopted by the Board on the ground that the notification “does not reach the threshold for a discipline matter”. Of the files examined in relation to prescribing practices only one (1) practitioner was Cautioned. The allegations in relation to this practitioner included the failure to monitor or inform of the potentially harmful drugs the practitioner had prescribed for the patient. While AHPRA recommended the notification be Investigated the NAC recommended a Show Cause Caution which was approved by the Board and resulted in a submission by the practitioner. The Board, on consideration of the submission, decided a Caution was the appropriate outcome.

274 Complaint/Notification CNS8 Health Quality and Complaints Commission s150(2) Notification and 150(3) Consultation with AHPRA dated 20.2.2012.
276 Complaint/Notification CNS8 QBMB A Record of Decisions and Actions arising, dated 14 August 2010.
277 Complaint/Notification CN573
280 Complaint/Notification CN50
It is of note that the decision to Caution does not address the issue of the practitioner’s competence, nor provide any oversight or supervision of the practitioner’s practice. The same situation arises when the Board makes a decision to Discipline a practitioner by Correspondence (under the *Health Practitioners (Professional Standards) Act* 1999). This decision was made by the Board in relation to:

- A notification by a co-regulatory authority that a practitioner had been prescribing Exefor in such excessive dosages that the patient required admission to hospital\(^{281}\);
- A notification from the Ethical Standards Unit of Queensland Health that the practitioner had written three (3) private prescriptions for Schedule 4 drugs without actually consulting the persons named on the prescriptions who also were not patients in the hospital\(^{282}\).

### 6.4 Boundary violations

There were 29 boundary violations (8% of targeted files) which were invariably of a sexual nature. Outcomes included 14 NFA’s, 8 referrals to QCAT and five (5) Discipline by Hearing. Refer Figure 6-4.

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\(^{281}\) Complaint/Notification CN591

\(^{282}\) Complaint/Notification CN287
In relation to boundary violations there was evidence that this type of allegation had been dealt with in an appropriate manner in the interests of protecting the public in terms of final outcomes. There is a high overall rate of disciplinary action, being 65% (15) of all such files, 8 of which were referred to QCAT and 6 referred to disciplinary hearings. The NFA rate was 35% (8). There is a recognisable pattern of recidivism in this type of complaint with two complaints against two practitioners, three against another and four against another practitioner. However, there are a number of files in which the time to first recommendation was lengthy. In files which led to disciplinary action these times varied from 20 days, through one (1), three (3) and eight (8) months up to 13 months. The following files are summarised to illustrate the forms of disciplinary proceedings taken as the nature of the alleged offence becomes more grievous:

- An allegation of inappropriate touching during a consultation was made by a patient.\textsuperscript{283} As a result of the subsequent investigation it was shown that the complaint was vexatious and there was insufficient evidence to demonstrate that the practitioner’s alleged conduct constituted serious sexual misconduct warranting imposition of “chaperone” conditions. In this instance there had been prompt reporting within the practice by the practitioner and others of general difficulties encountered with the

\textsuperscript{283} Complaint/Notification CN487
patient over a period of time. These more general issues had been well documented and appropriately dealt with by the practice. It was noted that the timing of the complaint was one day post refusal of licence by the Queensland Transport Department for the complainant based on a report made by the practitioner. NFA was taken against the practitioner;

- A former patient made a complaint which alleged that the practitioner had a consensual sexual relationship with her, and made uninvited sexual advances during a consultation. An investigation was conducted and it was concluded that there was insufficient evidence to form a reasonable belief that a disciplinary matter existed. It was recommended that the Board take NFA and write to the practitioner to remind him of his obligations in maintaining professional boundaries. Subsequently it was determined, following consultation with the HQCC, to rescind the previous decision and in substitution recommended to the QB MBA that in accordance with s118(1)(c)(iii) of the Act these matters be dealt with by the Board by establishing a disciplinary committee to conduct Disciplinary proceedings by way of a Hearing. It was noted that there were significant delays in the completion of this case. Eight months elapsed from date of complaint to first recommendation. The investigation took 11 months to report and a further four months for the final decision of the Board to be implemented. No conditions were imposed or undertakings made during the 833 days of the case history;

- A complaint was made alleging that the practitioner engaged in a sexual relationship with a patient over a period of at least seven years and that further, the practitioner had inappropriately touched two other patients and had had sexual relationships with another two patients. A period of 13 months elapsed before the first recommendation was made. An investigation was conducted and it was determined that there was sufficient evidence to form a reasonable belief that a disciplinary matter existed and that there was sufficient evidence that the practitioner had engaged in a sexual relationship with a patient. Furthermore it was shown that the practitioner had provided a sworn statement to the Board which was later proven to be false. The matter was referred to QCAT;

- It was alleged that the practitioner had violated professional boundaries by inappropriately touching the patient. The patient was a vulnerable person as she had a history of substance abuse and was dependent on the practitioner for the prescription of benzodiazepams. The Board accepted the patient’s complaint from the HQCC as two other complaints against the practitioner of a similar nature had been investigated.

284 Notifications Assessment Committee 6 June 2012
285 Complaint/Notification CN557
286 Performance and Professional Standards Committee 23 May 2011
287 Complaint/Notification CN393
288 Complaint/Notification CN89
While the time to first recommendation was short (20 days), it took 5 months to appoint an investigator, 11 months to complete the investigation and a further 4 months to the Board’s final decision. It was determined that there was sufficient evidence to form a reasonable belief that a disciplinary matter existed and the matter should be referred to QCAT to be dealt with in conjunction with the other three complaints previously referred to QCAT.\(^{289}\)

- The Board was informed by the HQCC in May 2009 that the QPS had received a complaint from a patient alleging sexual assault by a practitioner\(^ {290}\) during a consultation. Within 15 days the practitioner was issued with a notice to Show Cause why conditions should not be placed on his registration. The practitioner responded denying the allegations. In July 2009 MBQ was informed directly by QPS that another similar allegation had been made against the practitioner\(^ {291}\). Four weeks later the practitioner was again issued with a Show Cause notice and was reminded of a similar complaint that had been investigated by the Board in 2002 which, although it did not result in disciplinary action, could be taken into consideration as evidence of a pattern of behaviour. In September 2009, four months after the initial complaint, the Board imposed conditions on the practitioner’s practice (not to consult, assess, examine or treat a female patient without a chaperone present) and placed the matters into Investigation. A month later, in lieu of conditions, the practitioner entered into an undertaking to the same effect with the Board. By December 2009, a third complaint was received that the practitioner was not honouring the undertaking to have a chaperone present during consultations. The Board issued yet another Show Cause notice as to why conditions should not be imposed. Again the practitioner denied the allegations, advised that he would be retiring from medical practice in December 2009 and leaving Australia. Conditions were imposed by the Board in December 2009. The Investigation commenced in October 2009 proceeded, encompassing all matters, and was completed 17 months later in March 2011. It was concluded that there was sufficient evidence on the balance of probabilities that a disciplinary matter did exist as, whilst there were no witnesses to the actual alleged assaults, there were other factors that suggested that the practitioner did inappropriately touch patients in a sexual manner. QPS assessed that there was sufficient prima facie evidence to issue a warrant for the practitioner’s arrest on 2 charges of rape of his patients should the practitioner return to Australia.\(^ {292}\)

\(^{289}\) QBMPBA 27 April 2011  
\(^{290}\) Complaint/Notification CN449, Complaint/Notification CN452  
\(^{291}\) Complaint/Notification CN450, Complaint/Notification CN453  
\(^{292}\) QBMPBA21 March 2011
6.5 Official Misconduct

Official misconduct accounted for 87 complaints/notifications (24% of targeted files). The nature of the issues dealt with were wide ranging and specific allegations were often very difficult to assess and/or investigate. Examples of allegations within this category included fraudulent issue of certificates, inaccurate reporting and medico-legal assessments, fraudulent entries in medical records, unauthorised access to medical records, fraudulent claims for home and practice visits, coercion of patients to make unwise financial investments, breaches of supervisory duties or regulatory conditions and unacceptable communication/behaviour such as rudeness, intoxication and lewdness. The proportion of decisions for NFA was high in this category as illustrated in Figure 6-5.

![Figure 6-5 Outcomes from Official Misconduct](image)

The following provide examples of the outcomes in relation to complaints/notifications of official misconduct:

- An allegation was received from the Department of Immigration and Citizenship concerning a practitioner providing backdated medical certificates to visa applicants to

\[293\text{ Complaint/Notification CN260}\]

5 April 2013
cover non-attendance at educational courses which could place them in breach of their visa conditions. It was alleged that these certificates were issued to multiple patients on more than one occasion. Following a detailed submission from the practitioner, supported by relevant medical records, it was determined that the documents produced may be statements rather than medical certificates, and that the Department could choose to either accept or refuse the statements or ask for further information. It was decided to correspond with the practitioner drawing his attention to the policy obligations, specifically relating to “Good Medical Practice: A Code of Conduct for Doctors in Australia - section 8.8 – Medical reports, certificates and giving evidence” and remind the practitioner to be accurate and clear in providing statements/certificates to third parties and to take NFA on the complaints as they did not provide a ground for disciplinary action as required by s48 of the Health Practitioners (Professional Standards) Act 1999;

- It was alleged that the practitioner had issued medical certificates and other letters of a medical nature for her son, without disclosing her relationship to him, for the purposes of him receiving benefits (removal of financial liability) from a tertiary education provider. There were no disputed facts in the matter and the practitioner admitted acting improperly. It was noted that there was sufficient evidence on which the Board could form a reasonable belief that a disciplinary matter existed in relation to the practitioner and it was recommended that disciplinary proceedings by Reprimand be commenced.

- A number of allegations were received claiming that the practitioner was aggressive and intimidating towards colleagues and had assaulted one at work. It was believed the practitioner had a history of Bipolar Disorder and while some colleagues believed the practitioner was showing signs of a manic condition, while others did not. The practitioner had practised medicine in Queensland for several decades and had two previous unfounded complaints, one (1) in 1998 and one (1) in 1999. Both were assessed by the Health Rights Commission and closed with no further action being taken by the Commission or the Board. The practitioner was health assessed soon after receipt of the allegations and found not to be impaired. The Board was unable to progress investigation of the matters in relation to the assault/bullying allegations as the complainants would not assist in the investigation and there were no other avenues of enquiry available. The complainants indicated that subsequent professional behaviour had been appropriate and NFA was taken.

294 Complaint/Notification CN49 295 PPSC 28 June 2011 296 Complaint/Notification CN375
• There was a pattern of complaints against practitioners alleging poor standards of interpersonal behaviour such as rudeness and discourtesy towards patients and staff, arrogance, denigrating behaviour, disinterest and criticism of professional colleagues. These complaints usually led to a final decision of NFA either because there were insufficient grounds to proceed or there was extreme difficulty in establishing facts relating to the matters;

• In relation to allegations of financial fraud, it was alleged that a practitioner offered to look after a substantial sum of money ($75,000) belonging to a patient. Further it was alleged that no receipt was offered, the money was retained in a personal account and the patient was given small amounts of their money when they requested. Following a dispute, due to separation issues between the practitioner and his wife the money became unavailable to the patient. On investigation it was concluded that the practitioner’s partner was the person responsible for the situation and NFA was taken against the practitioner;

• In another matter it was alleged that a practitioner had used coercion to convince patients to invest money in an overseas investment scheme which subsequently failed. While the practitioner’s wife was the principal person involved, an investigation indicated that there was sufficient evidence for the Board to form a reasonable belief that a disciplinary matter existed and that the matter was referred to Discipline by Hearing.

6.6 Appropriateness of outcome by nature of complaint/notification

Final outcome by category of complaint/notification varied considerably. Prescribing irregularities (47 files) demonstrated the highest proportion of disciplinary action (62%). Of these 13 (27.5%) were referred to QCAT. The NFA outcome applied to 38% of files. The high proportion of disciplinary action in this category may be explained by the existence of agreed procedures and regulations in relation to prescribing against which complaints/notifications can be assessed. Boundary violations (29 files) resulted in the next highest rate of disciplinary action (51%). Explicit societal expectations in relation to appropriate behavior, especially behavior of a sexual nature, may have facilitated assessment and decision making in this category.

Poor medical practices and surgical outcomes (142 files) resulted in 61% NFA’s. Fourteen per cent went to Discipline by Hearing with 10% referred to QCAT. Only one practitioner was required to undertake Performance Assessment. Of the 58 Misdiagnosis/Failure to diagnose files 66% resulted in NFA. Discipline by Hearing was the outcome for 10% of files with the

297 Complaint/Notification CN466, Complaint/Notification CN349, Complaint/Notification CN579, Complaint/Notification CN162, Complaint/Notification CN320, Complaint/Notification CN36, Complaint/Notification CN35, Complaint/Notification CN517, Complaint/Notification CN566

298 Complaint/Notification CN299

299 Complaint/Notification CN367, Complaint/Notification CN366
remaining 24% leading to other disciplinary action, including one (1) referral to QCAT. Official misconduct files (87), with an NFA outcome of 76%, appeared to be more difficult to assess against matters of fact.
7 ACCEPTANCE/REJECTION OF AHPRA RECOMMENDATIONS

The 596 in-scope files were examined from the perspectives of acceptance or rejection of OMBQ/AHPRA recommendations by CAC/NAC/PPSC/QB MBA at the first and final decision making points.

7.1 First Recommendation

In relation to the first OMBQ/AHPRA recommendation, 61% (364) were accepted with 33% (198) rejected. A further 6% (34) were “Own Motions” by the Board, HQCC/delegate and were therefore classified as not applicable. These outcomes are outlined in Table 7-1 Acceptance of first recommendation for in-scope files and illustrated in Figure 7-1.

<table>
<thead>
<tr>
<th>Acceptance of first recommendation for In Scope cases</th>
<th>Acceptance</th>
<th>Rejection</th>
<th>Not Applicable (Own Motions, etc)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>214</td>
<td>71</td>
<td>23</td>
<td>308</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPRNLA)</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Notifications opened in FY 11</td>
<td>101</td>
<td>81</td>
<td>8</td>
<td>190</td>
</tr>
<tr>
<td>Notifications opened in FY 12</td>
<td>41</td>
<td>46</td>
<td>3</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>364</td>
<td>198</td>
<td>34</td>
<td>596</td>
</tr>
</tbody>
</table>

Table 7-1 Acceptance of first recommendation for in-scope files

![Figure 7-1 Acceptance of first recommendation for in-scope files](image-url)
The acceptance rate of first recommendation differed considerably between legacy and non-legacy files. Acceptance of first OMBQ/AHPRA recommendation occurred in 70% (214) of legacy files with 23% (71) resulting in rejection (Figure 7.2).

In comparison, 52% (150) of first recommendations by AHPRA were accepted with 44% (127) rejected in non-legacy files (Figure 7-3).

Figure 7-2  Acceptance of first recommendation - legacy files
In comparison, 52% (150) of first recommendations by AHPRA were accepted with 44% (127) rejected in non-legacy files (Figure 7-3).
The total number of files in which the first recommendation of OMBQ/ AHPRA was rejected was 198 as detailed in Table 7-2.

<table>
<thead>
<tr>
<th>Rejection of first recommendation</th>
<th>Rejecting further action</th>
<th>Rejecting NFA</th>
<th>Similar action proposed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>24</td>
<td>18</td>
<td>29</td>
<td>71</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPRNLTA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Notifications opened in FY 11</td>
<td>30</td>
<td>25</td>
<td>26</td>
<td>81</td>
</tr>
<tr>
<td>Notifications opened in FY 12</td>
<td>26</td>
<td>6</td>
<td>14</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>49</td>
<td>69</td>
<td>198</td>
</tr>
</tbody>
</table>

**Table 7-2  Rejection of first recommendation**

In relation to the legacy files in this category, 34% (24) rejected further action, 25% (18) rejected NFA and, in 41% (29) of files, similar action was proposed (Figure 7-4).

**Figure 7-4  Rejection of first recommendation - legacy files**

In these 71 legacy files in which the first recommendation of OMBQ/AHPR was rejected 18(25%) resulted in greater action while 23 (32%) resulted in action of a lesser magnitude.

Examples of greater action included the decision to Investigate\(^\text{300}\) or to institute Discipline by Correspondence\(^\text{301}\) when the first recommendation was for NFA. It was also noted that in eight

\(^{300}\) Complaint/Notification CN106, Complaint/Notification CN126, Complaint/Notification CN393, Complaint/Notification CN279

\(^{301}\) Complaint/Notification CN578
OMBQ/AHPRA recommended NFA yet the Board decided to seek further information from the practitioner, a hospital or other entity.

Action of lesser magnitude was demonstrated in files 303 for example, in which OMBQ/AHPRA recommended Investigation (10), Discipline by Hearing (1) and Discipline by Correspondence (1) yet the Board determined that there were no grounds for disciplinary action and a decision of NFA was made.

In some of these cases it would appear that the downgrading of the recommendation was inappropriate. For example, in a complaint 304 alleging the practitioner had issued a medical certificate without assessing the patient, AHPRA recommended that the allegations be investigated. The CAC’s recommendation to take NFA was adopted by the Board on the basis that there was insufficient evidence of grounds for disciplinary action against the practitioner.

Of those non-legacy files in which the first recommendation of AHPRA was rejected, 44% (56) rejected further action, 24% (31) rejected NFA and, in 32% (40) of files, similar action was proposed (Figure 7-5).

![Figure 7-5 Rejection of first recommendation - non-legacy cases](image)

In the 127 non-legacy files in which the first recommendation of AHPRA was rejected 32(25%) resulted in greater action while 54 (42.5%) resulted in action of a lesser magnitude. Greater
action, in files where the first recommendation was NFA, ranged from Investigation (3) through Show Cause Caution (10) to Show cause Conditions (1).

It was also noted that in 11 files AHPRA recommended NFA yet the Board decided to seek further information from the practitioner, a hospital or other entity.

There were 23 recommendations for Investigation which were rejected by the Board. In addition 26 recommendations for Show Cause Caution were not accepted. Across these files of lesser magnitude, 14 were noted by the Board to be lacking in substance.

As with the legacy files, it would appear in some of the non-legacy files that the downgrading of the recommendation was inappropriate. For example, in relation to a notification, alleging the practitioner had misdiagnosed the patient’s symptoms resulting in delays in treatment, AHPRA recommended an investigation. The NAC, however, recommended that the HQCC retain the complaint and, the Board in noting the recommendation, decided to take NFA. In the interests of public safety and maintaining public confidence in the profession, it would have been sound practice to have investigated the notification formally.

305 Complaint/Notification CN221, Complaint/Notification CN369, Complaint/Notification CN116
306 Complaint/Notification CN37, Complaint/Notification CN39, Complaint/Notification CN577, Complaint/Notification CN123, Complaint/Notification CN223, Complaint/Notification CN193, Complaint/Notification CN325, Complaint/Notification CN248, Complaint/Notification CN399, Complaint/Notification CN405,
307 Complaint/Notification CN475
308 Complaint/Notification CN37, Complaint/Notification CN435, Complaint/Notification CN363, Complaint/Notification CN41, Complaint/Notification CN174, Complaint/Notification CN539, Complaint/Notification CN131, Complaint/Notification CN407, Complaint/Notification CN132, Complaint/Notification CN202, Complaint/Notification CN327
309 Complaint/Notification CN215, Complaint/Notification CN321, Complaint/Notification CN48, Complaint/Notification CN347, Complaint/Notification CN80, Complaint/Notification CN99, Complaint/Notification CN383, Complaint/Notification CN344, Complaint/Notification CN353, Complaint/Notification CN416, Complaint/Notification CN200, Complaint/Notification CN442, Complaint/Notification CN487, Complaint/Notification CN56, Complaint/Notification CN60, Complaint/Notification CN306, Complaint/Notification CN494, Complaint/Notification CN179, Complaint/Notification CN178, Complaint/Notification CN92, Complaint/Notification CN130, Complaint/Notification CN194, Complaint/Notification CN595
310 Complaint/Notification CN4, Complaint/Notification CN26, Complaint/Notification CN425, Complaint/Notification CN477, Complaint/Notification CN100, Complaint/Notification CN61, Complaint/Notification CN258, Complaint/Notification CN380, Complaint/Notification CN237, Complaint/Notification CN397, Complaint/Notification CN268, Complaint/Notification CN323, Complaint/Notification CN235, Complaint/Notification CN267, Complaint/Notification CN185, Complaint/Notification CN189, Complaint/Notification CN255, Complaint/Notification CN415, Complaint/Notification CN404, Complaint/Notification CN467, Complaint/Notification CN469, Complaint/Notification CN220, Complaint/Notification CN292, Complaint/Notification CN209, Complaint/Notification CN456, Complaint/Notification CN384
311 Complaint/Notification CN442, Complaint/Notification CN56, Complaint/Notification CN60, Complaint/Notification CN185, Complaint/Notification CN255, Complaint/Notification CN469, Complaint/Notification CN146, Complaint/Notification CN456, Complaint/Notification CN587, Complaint/Notification CN215, Complaint/Notification CN4, Complaint/Notification CN26, Complaint/Notification CN100, Complaint/Notification CN235
312 Complaint/Notification CN48
7.2 Final Recommendation

The overall rate of acceptance by the Board of the final recommendation from OMBQ/AHPRA/CAC/NAC/PPSC was 89% (529) with 7% (41) rejected, and 4% (26) not applicable / open as detailed in Table 7-3 and illustrated in Figure 7-6.313

<table>
<thead>
<tr>
<th>Acceptance of final recommendation by the Board for In Scope cases</th>
<th>Acceptance</th>
<th>Rejection</th>
<th>Not Applicable (Open, etc)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>278</td>
<td>21</td>
<td>9</td>
<td>308</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPRNLA)</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Notifications opened in FY 11</td>
<td>163</td>
<td>15</td>
<td>12</td>
<td>190</td>
</tr>
<tr>
<td>Notifications opened in FY 12</td>
<td>80</td>
<td>5</td>
<td>5</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>529</td>
<td>41</td>
<td>26</td>
<td>596</td>
</tr>
</tbody>
</table>

Table 7-3 Acceptance of final recommendation by the Board for in-scope files

Both legacy (Figure 7-7) and non-legacy (Figure 7-8) files demonstrated very similar rates of acceptance, 90% legacy (278) and 87% non-legacy (251). Each had a rejection rate of 7% (legacy 21, non-legacy 19).

313 Twenty-six final recommendations are classified as non-applicable as the cases are still open at 30 June 2012 or have been closed under aged audit.
The total number of files in which the final recommendation was rejected by the Board was 41 (Table 7-4). Of these 21 were legacy files and 20 were non-legacy files.
Rejection of final recommendation

<table>
<thead>
<tr>
<th></th>
<th>Rejecting further action</th>
<th>Rejecting NFA</th>
<th>Similar action proposed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>10</td>
<td>1</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPRNLA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Notifications opened in FY 11</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Notifications opened in FY 12</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>4</td>
<td>14</td>
<td>41</td>
</tr>
</tbody>
</table>

**Table 7-4 Rejection of final recommendation**

For legacy files the Board rejected the final recommendation of NFA once (5%) and rejected proposed further action on 10 occasions (47%). In the remaining 10 (47%) files the Board proposed similar action (Figure 7-9).

In the 21 legacy files in which the final recommendation of OMBQ/AHPR was rejected 2 (10%)\(^{314}\) resulted in greater action from NFA to Discipline by Correspondence and Advice. Ten (50%) resulted in action of a lesser magnitude. In each of these files the final decision was NFA from recommendations for Discipline by Hearing (1)\(^{315}\), Undertaking (2)\(^{316}\), Discipline by Correspondence(2)\(^{317}\), Further Investigation and Other Decision (5)\(^{318}\). The remainder resulted in similar action.

As an example, a complaint alleging the practitioner was clinically incompetent in failing to diagnose and failing to appreciate the urgency of the treatment required, the OMBQ/CAC recommended the allegations were investigated. Based on the findings from the Investigation, the PPSC recommended the practitioner enter an Undertaking to undergo a period of supervised practice. The Board however decided to take NFA.

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\(^{314}\) Complaint/Notification CN578, Complaint/Notification CN328  
\(^{315}\) Complaint/Notification CN232  
\(^{316}\) Complaint/Notification CN521, Complaint/Notification CN476  
\(^{317}\) Complaint/Notification CN199, Complaint/Notification CN389  
\(^{318}\) Complaint/Notification CN398, Complaint/Notification CN457, Complaint/Notification CN540, Complaint/Notification CN457, Complaint/Notification CN471
For the non-legacy files the Board rejected the final recommendation of NFA three (3) times (15%) and rejected proposed further action on 13 occasions (65%). In the remaining 4 (20%) files the Board proposed similar action (Figure 7-10).

In the 20 non-legacy files in which the final recommendation of OMBQ/AHPR was rejected 3 (15%) resulted in greater action from NFA to Caution (2)\textsuperscript{319} and Show Cause Caution (1)\textsuperscript{320}. Thirteen files (27%) were converted by the Board to NFA from final recommendations of Show Cause Caution (9)\textsuperscript{321}, Show Cause Undertaking (1)\textsuperscript{322}, Caution (2)\textsuperscript{323} and Performance Assessment (1)\textsuperscript{324}. Five of the decisions to convert to NFA were based on submissions from practitioners\textsuperscript{325} while it was noted by the Board in another three (3) files that the notification was lacking in substance\textsuperscript{326}.

\textsuperscript{319} Complaint/Notification CN37, Complaint/Notification CN227
\textsuperscript{320} Complaint/Notification CN33
\textsuperscript{321} Complaint/Notification CN325, Complaint/Notification CN250, Complaint/Notification CN248, Complaint/Notification CN405, Complaint/Notification CN513, Complaint/Notification CN524, Complaint/Notification CN268, Complaint/Notification CN79, Complaint/Notification CN360
\textsuperscript{322} Complaint/Notification CN38
\textsuperscript{323} Complaint/Notification CN24, Complaint/Notification CN253
\textsuperscript{324} Complaint/Notification CN23
\textsuperscript{325} Complaint/Notification CN24, Complaint/Notification CN253, Complaint/Notification CN405, Complaint/Notification CN513, Complaint/Notification CN79
\textsuperscript{326} Complaint/Notification CN248, Complaint/Notification CN524, Complaint/Notification CN360
Figure 7-10 Rejection of final recommendation - non-legacy files

While there is a far lower rate of rejection of the final recommendation in the non-legacy files, there remain instances in which the rejection of the final recommendation by way of "downgrading" the severity of the recommendation appeared inappropriate. For example, a notification alleged the practitioner failed, over a period of time, to recognise and respond to the blood test results and presentation symptoms of a patient who was later diagnosed with pancreatic cancer and died shortly thereafter. The evidence indicated that positive tumour markers were evident in the blood results and ought to have been followed up by the practitioner at the time. The AHPRA/NAC recommended an Investigation and, based on the outcome of that investigation, made a further recommendation that the practitioner undergo a Performance Assessment. However, the decision of the PPSC adopted by the Board was to take NFA. The decision of the Board fails to address the obligation to ensure a practitioner’s competency to practise in the interests of protecting the public from risk of harm.
8 FINAL OUTCOMES

The final outcomes for in-scope cases are illustrated in Table 8-1  Outcomes for in-scope files and Figure 8-1 Outcomes for in-scope files.

### Table 8-1 Outcomes for in-scope files

<table>
<thead>
<tr>
<th></th>
<th>NFA</th>
<th>Undertaking</th>
<th>Conditions</th>
<th>Caution</th>
<th>Reprimand</th>
<th>Refer to Panel</th>
<th>Refer to Tribunal</th>
<th>Performance Assessment</th>
<th>Suspension</th>
<th>Disciplinary Correspondence</th>
<th>Disciplinary by Hearing</th>
<th>Advise</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy Cases (HPPSA)</td>
<td>128</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>300</td>
</tr>
<tr>
<td>Notifications opened prior to FY11 (HPPSA)</td>
<td>127</td>
<td>5</td>
<td>6</td>
<td>0</td>
<td>7</td>
<td>20</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>185</td>
</tr>
<tr>
<td>HPRNLA Notifications opened in FY 11</td>
<td>91</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>96</td>
</tr>
<tr>
<td>Total</td>
<td>403</td>
<td>10</td>
<td>8</td>
<td>33</td>
<td>1</td>
<td>8</td>
<td>58</td>
<td>0</td>
<td>12</td>
<td>42</td>
<td>3</td>
<td>580</td>
<td></td>
</tr>
</tbody>
</table>

![Outcomes for in-scope files](image)
Final outcomes, when analysed separately for legacy and non-legacy files, show a high degree of consistency. This is especially evident in the percentage of NFA and Referral to Tribunal decisions. There are minor variations in the other forms of disciplinary action taken as evident in Figure 8-2 and Figure 8-3.

Figure 8-2 Final outcomes for in-scope legacy files

Figure 8-3 Final outcomes for in-scope non-legacy files
Complaints/notifications reviewed were closed at various stages in the overall process. These stages are described as:

- **Assessment** - case is closed without going to investigation or panel/tribunal hearing. Can result in NFA, undertakings, conditions, cautions or referrals to health or performance assessments.
- **Investigation** - case is closed at the end of an investigation without referring the matter to panel or tribunal hearing. Can result in NFA, undertakings, conditions, cautions or referrals to health or performance assessments.
- **Performance Assessment** - case is closed after the Board or delegate has referred the practitioner for a performance assessment.
- **Panel** - Case is referred to a performance and professional standards panel hearing (HPRNLA files only)
- **Discipline by hearing** - case is referred to a panel hearing (HPPSA files only)
- **Discipline by correspondence** - case is referred to a panel hearing (HPPSA files only)
- **Referral to Tribunal** - case is referred to a tribunal hearing

The stage at which a complaint/notification was closed has been separately determined for legacy and non-legacy files as illustrated below in Table 8-2 and Table 8-3.

<table>
<thead>
<tr>
<th></th>
<th>&lt; 60 days</th>
<th>60-119 days</th>
<th>120-179 days</th>
<th>180-269 days</th>
<th>270-364 days</th>
<th>365-539 days</th>
<th>540-730 days</th>
<th>&gt; 2 years</th>
<th>Open</th>
<th>Total Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>5</td>
<td>14</td>
<td>9</td>
<td>23</td>
<td>29</td>
<td>46</td>
<td>24</td>
<td>16</td>
<td>1</td>
<td>159</td>
</tr>
<tr>
<td>Investigation</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>14</td>
<td>28</td>
<td>8</td>
<td>6</td>
<td>66</td>
</tr>
<tr>
<td>Discipline by Hearing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>11</td>
<td>26</td>
<td>0</td>
<td>42</td>
<td>66</td>
</tr>
<tr>
<td>Discipline by Correspondence</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>11</td>
<td>42</td>
</tr>
<tr>
<td>Referral to Tribunal</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>30</td>
</tr>
</tbody>
</table>

**Table 8-2  Stage of closure for Legacy In-scope Files**

<table>
<thead>
<tr>
<th></th>
<th>&lt; 60 days</th>
<th>60-119 days</th>
<th>120-179 days</th>
<th>180-269 days</th>
<th>270-364 days</th>
<th>365-539 days</th>
<th>540-730 days</th>
<th>&gt; 2 years</th>
<th>Open</th>
<th>Total Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>22</td>
<td>42</td>
<td>24</td>
<td>53</td>
<td>20</td>
<td>29</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>195</td>
</tr>
<tr>
<td>Investigation</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>13</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>1</td>
<td>8</td>
<td>56</td>
</tr>
<tr>
<td>Performance Assessment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Panel</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Referral to Tribunal</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>28</td>
</tr>
</tbody>
</table>

**Table 8-3  Stage of closure for non-legacy in-scope files**

This analysis of stage at closure illustrates that most files were closed during the assessment stage. These data also indicate that the implementation of investigations appears to be delayed for a minimum of six (6) months. The largest grouping of legacy files closed at assessment appears to be delayed for a period of 12 months. By comparison, most non-legacy files closed at assessment are dealt with earlier.

The similarity between legacy and non-legacy files in the final outcome is striking.
• the percentage of notifications in which final decision is in NFA for legacy files (69%) and non-legacy files (70%);
• in only 10% in both legacy non-legacy files was the matter referred to a tribunal (see figures 82 and 83).

On the reasonable basis that the legacy and non-legacy files reflect on conduct by practitioners which is equally appropriate and inappropriate, this would suggest that the disciplinary standards set by the MBQ and the new AHPRA/QBMBBA are similar. As illustrated by the numerous examples in earlier section of this Final Report, neither the old processes nor the new ones under AHPRA/QBMBBA consistently adequately protect the public.
9 CONCLUSION

The panel has completed the examination of the 596 files which were determined as being within the scope of the Chesterman Report Recommendation 2 Terms of Reference. Of these files, 233 were considered by the panel to have been dealt with in a timely and appropriate manner, compliant with the legislative objectives. This report therefore focuses on the 363 files (224 legacy and 139 non-legacy) which the panel considered as not having been dealt with in a manner that was timely and/or appropriate and/or in compliance with the legislative objectives.

The issues emerging from these files included:

- delays in the timeliness of complaints/notifications progressing from receipt through the various assessment and disciplinary processes to a final decision by the Board.
- a lack of consistency and predictability of outcomes in the decisions of the Board across complaints/notifications of a similar nature;
- considerable delays and inconsistencies in a significant number of files resulting from the cross-jurisdictional referral, consultation and information sharing obligations imposed under the current legislative scheme.

Legacy Files

The panel’s assessment of the "legacy" files, which were subject to the Health Practitioners (Professional Standards) Act 1999 and handled by the MBQ or transitioned from the MBQ to AHPRA/QB MBA, was that a significant proportion of the in-scope files had not been handled in a timely manner. Seven (7) were dealt with in less than 60 days while 83 took over two (2) years.

The panel considered of particular significance the extensive delays in the time taken from the receipt of a complaint to the first assessment meeting, and the time taken from a decision to investigate, to the conclusion of an investigation. Despite the legislation imposing an obligation on the Board to ensure the investigation process was conducted as “quickly as possible having regard to the nature of the matter” the delays were manifestly long, varied considerably, and indicative of a low level of compliance with the legislative prescription.

In the majority of the files examined, delays in processing a complaint during the stages of the process (assessment, appointment of an investigator, completion of an investigation) resulted in the practitioners, who potentially posed a risk of harm to the public, continuing to practice without their competency having been assessed or the safeguards of conditions, undertakings, supervision or monitoring being in place. In terms of the time taken from receipt of complaint to a final decision by the Board the time ranged from 36 to 2,368 days which, even allowing for
differences in the clinical significance of complaints, is indicative of a process lacking in
direction, management and rigour.

The panel considered the appropriateness of the decisions of the Board in the legacy files and
formed the view that the outcomes were neither consistent nor predictable based on the nature
and/or clinical significance of the complaints. In a significant number of the legacy files the
decisions of the Board did not appear to be sufficiently directed to whether the practitioner was
competent to practice. The panel formed the view that in a very significant number of the files
the decisions of the Board were difficult to reconcile with the overriding legislative obligations.
The panel thereby concluded that the processes of the Board, as evidenced by the time taken and
decisions of the Board in a significant number of the files, failed to “protect the public…uphold
the standards of practice…and maintain public confidence” as required under the Health

Non-legacy Files

The panel considered the timeliness of the progression of non-legacy files in light of the
legislative obligations imposed on the Board under the Health Practitioner Registration National
Law Act 2009. The legislation provides that the Board must ensure that a preliminary assessment
is conducted on a notification “within 60 days after receipt” and an investigation is conducted
“as quickly as practicable”.

The non-legacy files evidenced a significant number of notifications which were not progressed
to assessment within the legislatively prescribed timeframe of 60 days nor investigated “as
quickly as practicable”. In addition, it was the opinion of the panel that the inordinate delays in
the time taken to progress a significant number of notifications through the process after receipt,
did not correlate in any predictable or consistent way with the nature or seriousness of the
notification, any history of prior or similar complaints/notifications, or the source of the
notification, such as the Office of the State Coroner. As with the legacy files, the delays in
processing a complaint during these stages of the process resulted in the practitioners, who
potentially posed a risk of harm to the public, continuing to practice without their competency
having been assessed or the safeguards of conditions, undertakings, supervision or monitoring
being in place.

The time taken from receipt of a notification to a final decision by the Board in the non-legacy
files ranged from 110 to 635 days with the average time for notifications raised in Financial Year
2011 being 288 days. Although the length of time taken from receipt of a notification to a final
decision by the Board varied greatly in both the legacy and non-legacy files it was evident that
the overall length of time is progressively decreasing since the transition on 1 July 2010.

Notwithstanding the improvements made, the panel concluded that the processes followed by
AHPRA, and the QBMA, do not meet reasonable expectations that notifications are
consistently and predictably dealt with in a timely manner. Furthermore, there were a number of
examples where serious notifications, indicating that the public was at risk of harm, were not
handled with the urgency that was required in the particular circumstances. Accordingly, the processes followed by AHPRA and the Board demonstrated an inability to effectively prioritise and manage the progression of notifications from the time of receipt to the final decision of the Board.

A review of the files in which ‘immediate action’ was taken by the Board demonstrated that the existing provisions in the Health Practitioner Regulation National Law Act 2009 effectively hindered the Board in taking actual ‘immediate action’ when it reasonably believed a practitioner posed a serious risk to the public. The panel considered that the current provisions require amendment to empower the Board to immediately respond as opposed to engaging in an exchange or correspondence and seeking submissions from the practitioner before any action can be taken.

The panel considered the appropriateness of the decisions of the Board in the non-legacy files and formed the view that there was no pattern of consistency or predictability of outcomes across complaints/notifications of a similar nature. In addition it was found that the decisions lacked congruence with the nature and clinical significance of the complaints/notifications. For example, there were a considerable number of files where it was indicated that assessment, confirmation or monitoring of a practitioner’s competence to practice was required, however there was a failure to take such action. This was evident in files in which the Board made a decision to Caution a practitioner, a step which did not address the issue of the practitioner’s competence, nor provide any oversight or supervision of ongoing practice.

There was a considerable degree of variability in relation to the outcomes of the various categories of complaints/notifications. Prescribing irregularities demonstrated the highest proportion of disciplinary action (62%) with 27.5% being referred to the QCAT and the Board deciding to take NFA with respect to 38%. Boundary violations resulted in the next highest rate of disciplinary actions at 51% of the files. The clear legislative framework applicable to drugs and poisons in Queensland and the explicit societal expectations in relation to appropriate behaviour, especially behaviour of a sexual nature, may have facilitated assessments and decisions in these categories of complaints/notifications. Conversely, the rate of disciplinary action in response to official misconduct allegations was only 14%. This may be indicative of the Board’s difficulty in assessing the precise parameters for disciplinary measures in response to this category of conduct, or a perception by the Board, that this type of conduct does not warrant a disciplinary outcome.

Complaints/notifications that were of a specific clinical nature had lower rates of disciplinary action. Of the complaints/notifications relating to misdiagnosis/failure to diagnose, 34% resulted in disciplinary action. Complaints/notifications of poor medical practices and surgical outcomes resulted in a disciplinary action rate of 38%. As noted in relation to the legacy files the panel was of the view, based on the in-scope files for review that the rate of disciplinary action was low if the objective of the disciplinary process is protection of the public from risk of harm.
Given that the practitioners whose in-scope files were examined have been fully dealt with by the Board, there are no reasonable grounds for the matters determined by the Board to be reconsidered. However, should there be evidence of criminal acts then it is open for the Queensland Police Service to bring charges. These aspects are matters which have been considered in the report prepared by Mr J. Hunter SC and are outside the terms of this panel.

The cross jurisdictional referral and consultation obligations imposed respectively under the *Health Practitioners (Professional Standards) Act 1999, Health Quality and Complaints Commission Act 2006* and the provisions of the *Health Practitioner Regulation National Law Act 2009* were considered, by the panel, to result in considerable delays and inconsistencies in both the progression and outcomes of complaints/notifications in a significant number of the files. The panel was of the opinion that the current legislative requirement for two (2) separate and distinct entities to co-manage notifications through reciprocal referral and consultation processes is an unnecessary duplication of activities and resources and requires immediate consideration either to change the provisions of the legislation or consolidate the roles of the entities.

The panel considered that changes to the processes by AHPRA and the Board which would improve timeliness and suitable prioritisation include:

- appointing one or more experienced and senior investigators to conduct “triage” on notifications, fast tracking investigations and Board decisions in matters which raise immediate concern about the safety of the public based on the nature of the notification, the source and detail of the notification and the nature of prior notifications (if any) concerning the practitioner;

- introduction of a defined “triage” process so as to ensure that appropriate priority is given to notifications from entities which have undertaken some initial form of investigation and have experience in assessing the conduct and behaviour of practitioners. Examples of such entities to include the Office of the State Coroner, Queensland Health and private health care institutions;

- establishing a more effective case management system whereby:
  - timelines for assessment, investigations and decisions are established;
  - overview systems are put in place so deviations from timelines are identified and managed to ensure that the timeline is met or, when necessary modified to take into account unpredicted developments;
  - any such modifications to the established timeline should be subject to being overruled by the Board;

- simplifying the process whereby the multiple internal referrals of decisions between committees and the Board are streamlined and endorsed by the Board rather than the existing process whereby the Board is required to endorse each individual decision.
In relation to the appropriateness of decisions, the panel concluded that there was clear evidence that the processes followed by AHPRA and the QBMBBA to reach decisions based on notifications, were not adequately protecting the public. In particular:

- the decision making processes for the progression of a notification from receipt to final decision did not appear to be consistent in application across notifications of a similar nature;
- practitioners who were identified by expert opinions, Investigation Report findings (and recommendations) and the Boards own Reasons for Decision as having demonstrated a lower standard of professional behaviour, skill and competence often faced little or no sanctions. This was the outcome for a significant number of complaints/notifications based on clinically significant allegations. A matter of great concern to the panel was the disproportionately high level of Board decisions to take NFA in response to complaints/notifications, which on their face, evidence the basis for significant concern, have been referred by the State Coroner after an Inquest or by Queensland Health or private sector health facilities after internal investigations.

The members of the panel had sufficient experience to be able to come to a view that the decision making processes taken by AHPRA and the Board are much more lenient in relation to medical practitioners than other regulated practitioners.

Having reviewed the decisions made by the QBMBBA in relation to the “non-legacy” files, the panel came to the view that consideration should be given to the following changes:

- to ensure and improve consistency of decisions, a formal process should be put in place whereby prior decisions of the Board and/or of QCAT, in relation to similar matters, are formally reviewed by the Board prior to a new decision being taken to ensure that subsequent matters are in range and consistent over time;
- this review of decisions should include decisions taken for similar notifications and findings in relation to other regulated health professionals such as nurses, pharmacists and dentists;
- to ensure that the process is transparent and that the decisions of the Board are subject to public scrutiny, summaries of the decisions of the board, suitably de-identified, should be released on a regular basis;
- to ensure consistency across the various regulated professions, the membership of the Board should be changed promptly so that a majority of its members are not medical practitioners. It is suggested that:
  - the chair of the Board is not a medical practitioner;
- a proportion of the new members includes practitioners other than medical practitioners who have served on boards which regulate other practitioners (such as nurses, dentists and pharmacists); and
- a higher percentage of community members.
ATTACHMENT A

QUEENSLAND MINISTER FOR HEALTH

CMC REPORT INTO ALLEGATIONS MADE BY MS JO-ANNA BARBER

RECOMMENDATION 2

TERMS OF REFERENCE

1. Overview

In April 2012, the Parliamentary Crime and Misconduct Commission received a purported public interest disclosure from Ms Jo-Anna Barber containing allegations relating to the conduct, regulation, registration and discipline of medical practitioners in Queensland. The matter was referred to the Crime and Misconduct Commission (CMC).

On 1 May 2012, Mr Richard Chesterman AO RFD QC was appointed by the CMC pursuant to section 265 of the Crime and Misconduct Act 2001 (Qld) to undertake an assessment and advise the CMC in relation to Ms Barber’s allegations.

The assessment report was completed on 11 July 2012 and contained a number of recommendations for consideration by the Minister for Health.

In accordance with recommendation 2 of the assessment report, the Minister for Health has requested that AHPRA appoint a panel of three, nominated by the Minister, to examine certain MBO/QBMB and AHPRA files to determine whether QBMA has made timely and appropriate responses to the complaints and notifications and, in relation to certain matters, is achieving the objectives of the Health Practitioners (Professional Standards) Act 1999 (Qld).

2. Appointment

The Minister has recommended that the following persons are appointed to conduct the review:

(a) Dr Kim Elizabeth Forrester;

(b) Adjunct Professor James Henry Houston; and

(c) Professor Elizabeth Anne Davies.

3. Scope of the review

3.1 Recommendation 2

"That there be a review of all the cases of misconduct or alleged misconduct by medical practitioners, dealt with by QBMA or in which AHPRA has recommended disciplinary action against a medical practitioner, including cases in which the Notification Advisory Committee and/or QBMA rejected a recommendation by AHPRA to take disciplinary action. The review should be undertaken by a panel of three comprising a legal practitioner, a medical practitioner and someone who has served on regulatory boards and has a reputation for decisiveness. The purpose of the review should be to determine whether QBMA has made timely and appropriate responses to the complaints and recommendations; and whether it is achieving the objectives of the Health Practitioners (Professional Standards) Act 1999, set out in s 6, to protect the public, uphold standards of medical practice and maintain public confidence in the medical profession."

3.2 Files to be reviewed

(a) Officers from AHPRA and QBMA, will compile the relevant records for review in accordance with these Terms of Reference.

(b) The review will be limited to files of MBO/QBMB and AHPRA:

(i) where the MBO had started but not completed dealing with a complaint or notification against a medical practitioner prior to 1 July 2010 and the matter
has now been transferred to QBEMBA under the Health Practitioner Regulation National Law Act 2009; or

(ii) where the QBEMBA has dealt with the matter or where AHPRA has recommended disciplinary action against a medical practitioner on or after 1 July 2010.

(c) Subject to paragraph 3.2(b) above, the review will be of all files of MBQ/QBEMBA and AHPRA where:

(i) a medical practitioner has engaged in misconduct or it was alleged in a complaint or notification that a medical practitioner had engaged in misconduct; and

(ii) the QBEMBA has made a decision in relation to a complaint or notification about a medical practitioner (including those files where an interlocutory decision has been made to take action and that action is pending). For the avoidance of doubt, this will include a decision by the QBEMBA (or delegate) to accept an undertaking in response to, or subsequent to, a complaint or notification about a medical practitioner.

(d) The term 'misconduct' should be taken to mean:

(i) For a complaint dealt with prior to 1 July 2010, 'unsatisfactory professional conduct' as defined under the Health Practitioners (Professional Standards) Act 1999;

(ii) For a complaint or a notification dealt with on or after 1 July 2010, 'professional misconduct' or 'unprofessional conduct' as defined under the Health Practitioner Regulation National Law Act 2009.

3.3 Process of review

The panel should conduct a review of the identified files and meet to discuss their views in relation to each matter before finalising their report.

3.4 Determination

(a) For each of the matters reviewed, the panel is required to form a view as to whether the QBEMBA:

(i) has made timely responses to the complaints and recommendations made to it;

(ii) has made appropriate responses to the complaints and recommendations made to it; and

(iii) for those complaints initially dealt with prior to 1 July 2010 and transferred to the QBEMBA, is achieving the objectives set out in section 6 of the Health Practitioners (Professional Standards) Act 1999 (Cth).

(b) The panel should have particular regard to those matters where:

(i) Action is recommended by AHPRA and no action is taken by the QBEMBA (or delegate);

(ii) Action is recommended by the Notification Assessment Committee and no action is taken by the QBEMBA (or delegate);

(iii) Action is recommended by the Performance and Professional Standards Committee and no action is taken by the QBEMBA.
(c) If there are differing views about a matter between appointed members of the
review panel, those matters should be outlined in the report.

4. Preparation of a report

The panel will prepare a report referencing each of the matters reviewed and its
opinion in relation to the matters set out in 3.4.

The report will be provided to the Minister for Health.

This report is to be completed by 28 February 2013

Dated this 1st day of December 2012

Queensland Minister for Health

5 April 2013

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